Maternal and Child Health Services
Title V Block Grant

State Narrative for Indiana

Application for 2008
Annual Report for 2006

Document Generation Date: Thursday, October 04, 2007

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and Certifications are kept on file at the Indiana State Department of Health both in the Finance Department and in the office of the MCSHC Grants Coordinator with the hard copy of the grant application. They are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

The State Title V program solicited public comments for this application by placing an Executive Summary of the FY 2006 application on the MCSHC web page. The web page provides the public an opportunity to review the Executive Summary and provide comments. After MCHB review, access to the entire application is also provided on the website. Copies of the Executive Summary were made available upon request and were also accessible in government document sections of thirteen public libraries across the state. A legal notice was placed in all major newspapers in the state alerting readers to the placement of the documents.

ISDH posted the 2007 application summary on the MCSHC web page and distributed the summary and the application electronically to the membership of the various MCSHC advisory committees and to all public libraries in the State. All public comments are recorded along with ISDH MCSHC response and all comments and responses are used during the preparation of the application for the following year. ISDH will announce the web location of the executive summary by legal notices placed in all major newspapers in the state.

Beginning with the FY 2007 application, MCSHC is making narrative sections of the application available to an advisory group and requesting input via e-mail.

/2008/The FY2008 application summary was sent electronically to the membership of the advisory committee to MCSHCS. MCSHCS received twenty two comments and several changes were made based on the suggestions. The application and an executive summary will be placed on the MCSHC website.//2008//

II. Needs Assessment

In application year 2008, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

Summary of Needs Assessment for the Block Grant 2008

Since the submission of the FY 2006 Needs Assessment and the FY 2007 update, Maternal and Children's Special Health Care (MCSHC) Services has continued to focus on improving perinatal outcomes particularly those related to alcohol, tobacco, and other drug use statewide and by county. Assessments have been completed or are in progress which will assist MCSHC staff in educating local communities about problems and in developing local intervention plans to impact and improve national and state performance measures. (Please see the Needs Assessment Attachment to the grant application for specific highlights of the data and recommendations of the studies).

During FY 2007 additional statistical analyses were completed based on Vital Statistics data. Trends in Birth Outcomes in Indiana Counties--Statistics from Live Birth Data from 1990-2004 was published in March 2007 and Trends in Birth Outcomes in Indiana--Statistics from Live Birth Data from 1990-2005 was published in May 2007. Smoking During Pregnancy in Indiana, 1990-2004, Statistics from Live Birth Data was published in September 2006.

The first two studies present statistics on time trends in low birth weight, preterm birth, selected maternal characteristics and a variety of delivery methods (including cesarean delivery rates) by race and Hispanic origin of the mother over time as reported on birth certificates, according to the mother's Indiana residence at birth. The latter focuses on prenatal smoking statistics and includes the impact of urbanization on prenatal smoking.

Alcohol, Tobacco and Drug Use by Pregnant Women in Indiana was published September, 2006. This study was requested by the Indiana legislature. The purpose of this study was to collect information that would improve the understanding of the size of the problem of alcohol, tobacco, and drug (ATOD) use by pregnant women in Indiana; to determine the barriers, perceived or real, that keep pregnant ATOD users from getting needed treatment; and to suggest strategies that could be undertaken to improve the access to treatment services.

A Consensus Statement on Substance Use Disorders and Pregnancy was published in March, 2007. It was facilitated by the Indiana Perinatal Network, Inc., a Title V funded grantee which assist MCSHC in infrastructure building and policy development regarding perinatal health. These two external documents supported by the statistical trends provide recommendations for intervention.

With these statistics and assessments, the information gathered in the Community Forums and focus groups in the last two years, needs assessments, and recommendations, MCSHC has begun holding community disparity summits in five counties that focus on reducing disparity in perinatal health to engage and empower local groups to implement activities to impact ATOD use and other issues that inhibit access to care and impact poor outcomes of pregnancy. In addition, presentations for providers on tools to use to assess and intervene with pregnant smokers are being presented in five of the more rural focus counties and MCSHC is partnering with Indiana Rural Health Association to provide training in physicians' offices in five southern counties with the highest rates of smoking among pregnant women, as mentioned in the Title V grant application.

In recently published reports and state rankings related to access to care (insurance coverage and the state Medicaid program), Indiana was determined to be "mediocre" in number of uninsured and "poor" for Medicaid program qualities (eligibility, scope of services, quality of care and provider reimbursement). In the Robert Wood Johnson's Cover the Uninsured report distributed during the Cover the Uninsured Week, April, 2007, the State Profile for Indiana (based on 2003 data) reveals that 14.2% of Indiana's population and 9.0% of Indiana's children are uninsured. Based on 2004 and 2005 Medicaid data from Kaiser Family Foundation's Commission on Medicaid and the Uninsured and other data gathered and reported by Public Citizen, Indiana's state Medicaid program was ranked as one of the 10 worst programs in the nation. These rankings should change with recent legislation to expand Medicaid and health insurance coverage to families up to 200% of FPL and SCHIP coverage up to 300% of FPL.

III. State Overview
A. Overview
Section III. State Overview

A. Overview

Indiana elected a new Governor, Mitchell E. Daniels, Jr. in 2004. Governor Daniels appointed Dr. Judith Monroe as the State Health Commissioner and Medical Director for Medicaid, the first woman appointed to head the health department and the first person to hold both positions simultaneously. Dr. Monroe's background is Family Practice Residency Training and Primary Care.

PRINCIPLE CHARACTERISTICS of STATE HEALTH NEEDS
Population -- 6,195,643
Statewide, Indiana's population grew by about 3 percent between 2000 and 2002, with most of the growth coming from more births than deaths and people moving to the state from other countries. Indiana grew at a slightly faster pace than neighboring states from 2000 to 2003, but well below the fastest growing states such as Georgia, Nevada and Idaho, all above 7%. ***/2008/ Indiana's population in 2005 was 6,271,973. With the 24th highest population growth rate among the states in 2005, Indiana continued to grow at a slightly faster pace than neighboring states with the exception of Kentucky.//2008//***
Source: http://www.incontext.indiana.edu/2006/january/3.html

Hundreds moved out of Madison County between 2000 and 2004. Between 2001 and 2004, manufacturing jobs in Madison County dropped from 9,781 to 7,180. Henry, Grant, Wayne, Randolph and Rush counties in east-central Indiana also experienced population declines after the loss of manufacturing jobs. Widespread population loss also occurred in Newton, Vermillion, Knox and Posey counties along the Illinois border. The drops in Vermillion and Knox are attributed to deaths outnumbering births./2007/Madison and Grant Counties lead the state for manufacturing job losses from 2001 - 2005. These counties industries are very reliant on General Motors. Other counties with high manufacturing job losses include White, Fayette, Johnson and Wabash Counties.//2007//
/2008/ Honda announced plans and began building a new automotive facility in Decatur County. Population growth in Indiana continued to move out to areas surrounding the metropolitan centers of Indianapolis, Chicago, and Louisville while the major cities in Indiana did not experience significant population growth. //2008//
Source: http://www.ibrc.indiana.edu/ibr/2006/summer/article3.html

Whites make up 89% of Indiana's population. Approximately 8.5% of the state's population is Black. Marion County (Indianapolis) and Lake County (Chicago area) have the highest concentrations of African Americans, representing 24%-25% of each county's population. Other counties with urban centers and manufacturing job concentrations also have significant numbers of African Americans, the next highest being St. Joseph, Allen and LaPorte Counties at 10%-12% of their population.
/2008/African Americans are about 8.4% of Indiana's population. Roughly half of Indiana's African American high school graduates enrolled in college in 2005.//2008//
Source: http://news.uns.purdue.edu/UNS/html3month/2006/060923SP-JischkePBAO.html
Target = enroll in a college

The Ku Klux Klan has resurfaced across Lake, Porter and LaPorte Counties and was implicated in the burning of a house being built for a black family in Lake Station. The City of Gary has started community meetings to address recent racism.
/2008/Indiana is one of 19 states identified by the Anti-Defamation League as having notable growth in KKK activity.//2008//
Source:
http://www.adl.org/learn/ext_us/kkk/intro.asp?LEARN_Cat=Extremism&LEARN_SubCat=Extremism_in_America&xpicked=4&item=kkk
Target = notable for active or growing Klan chapters

At 1.2% of Indiana's population, Asians are the fastest growing minority with the highest concentration at 4.5% in Tippecanoe County, home to Purdue University. Monroe and Hamilton Counties also have more than 2% Asian representation. Numerically, the greatest concentration of Asians is in Marion County (12,325 = 1.4%).
/2008/Asians remain the fastest growing racial demographic in Indiana, experiencing a population growth of more than 19% from 2000 to 2005.//2008// Source:
http://www.stats.indiana.edu/stats_dpage/dpage.asp?id=72&view_number=2&menu_level=&panel_number=
Select Indiana, 2005, Overview Race

The largest increase among Indiana's population has been the Hispanic ethnic group. Hispanics make up 3.5% of the state's population with the greatest concentration in Lake County, representing 12.2% of the population. The next closest county is Elkhart at 8.9%. Other counties that show the largest growth in Hispanic population include Marion, Allen, Tippecanoe and Porter. The influx of Spanish speaking people has caused hospitals, clinics, public safety and educational institutions to train personnel in Spanish language and Hispanic culture.
/2008/ Hispanics made up 4.5% of the population in 2005. The Hispanic population in Indianapolis more than tripled from 1998 to 2004, making them the fastest growing demographic in the city. This increase is a product of an influx of Hispanic residents and a baby boom among this population. //2008//
Source: http://www.homepages.indiana.edu/2006/02-24/story.php?id=442
Target (Sic) = fasting growing population group in Indianapolis

The second fastest growing minority population in Indiana is the Amish, with populations expected to double in 20 years. Concentrated in the northeast corner of the state, Indiana's Amish face unique challenges. The Elkhart-LaGrange settlement is the 3rd largest in the U.S. and while the U.S. Census does not track Amish populations, local estimates show about 3,300 school age (1st-8th grade) Amish children in the Elkhart-LaGrange settlement. According to estimates developed by Indiana University of Fort Wayne through the Amish Youth Vision Project, the total Amish population could be as high as 45,000 in this part of the state. An unusually high percentage of this population works in local factories -- more than 40% of Amish men.

During late teen years through their early twenties, Amish youth are not required to join the church and are not bound by its teachings. This tradition, known as Rumspringa, grows from the belief that Amish must join the church of their own free will. However, as documented in "The Devil's Playground," a video documentary prepared for the Public Broadcasting System, this population, particularly young Amish men are extremely vulnerable to drug use and other illegal and occasionally violent behavior -- particularly for factory workers who, unlike the Amish working in farming and small business, have free time, low cost of living and significant disposable income. Population increases and limited land availability put additional pressures on the Amish as their larger communities grow to several times the traditional settlement size./2007/The Amish population referred to is the Old Order Amish. The estimates of population were developed by

Steven M. Nolt Ph.d. and Thomas J. Meyers Ph.d. of Goshen College. The Amish Youth Vision Project funded primarily through ISDH, focuses on drug and alcohol education in hopes to reduce usage among Amish youth. One conference for law enforcement dealing with responding to Amish youth has been held, and a second conference to include mental health/social service providers is planned for the fall of 2006. A counseling group is providing drug and alcohol classes exclusively to Amish youth led by Amish leaders. Other Amish communities are now requesting assistance to implement their own programs.//2007//
/2008/Due to budget constraints, ISDH ended support for the Amish Youth Vision project in FY 2007, one year earlier than anticipated. Fortunately, the program has been funded by the Dekko Foundation. The project has now trained hundreds of police officers in ways to work more effectively with the Amish population to curb drug crimes among Amish youth. The project has also been very effective with involving and facilitating leadership within the Amish community. The bishops and elders now take the lead role in organizing the education for parents in more effective ways to help their adolescent and adult children through Rumspringa.//2008//
Source: Amish Youth Vision Project 2006 annual report to ISDH and Dekko Foundation

American Indians are one of the smallest minority groups in Indiana, making up 0.6% of the state's population, trailed only by Pacific Islanders at 0.1%. This population is scattered across the state. Only three counties, Marion, Lake and Allen have total American Indian populations of more than 1,000. Most counties have fewer than 100.
/2008/ Indiana's American Indian & Alaskan Native population grew by 6.4% while the population of Native Hawaiians & Pacific Islanders experienced a growth rate of 18.7% between 2000 and 2005. This population is so small, that the actual change in population during that period was an additional 539 persons.//2008//
Source:
http://www.stats.indiana.edu/stats_dpage/dpage.asp?id=72&view_number=2&menu_level=&panel_number=
Select Indiana, 2005, Overview Race

While Indiana's labor force grew, employment levels steadily decreased from 1999 to 2003, causing a jump in the unemployment rate from 3% to 5.1%. This current unemployment rate is below average for the Midwest region. Kentucky has the lowest regional unemployment rate at 4.5%; Michigan has the highest at 6%./2007/Indiana's current unemployment rate is 5.0%, slightly above the 4.88% average for the Midwest. Minnesota had the lowest rate at 3.7% and Michigan the highest at 6.0%. The national average is 4.6%//2007//
/2008/Indiana's unemployment rate in November 2006 was 4.8% equal to the Midwest regional rate but above the national rate of 4.5%.//2008// Source:
http://www.bls.gov/lau/home.htm
Target = Unemployment Rates, seasonally adjusted

Between 1999 and 2002, Indiana's poverty rate increased from 8.7% to 9.6% - still below the national average of 12.1%. The U.S. Census estimated in 2002 that 11.9% of Indiana's children live in poverty, with a higher rate of 14.5% for children under age 5. In Indianapolis, approximately 15,000 people are homeless in any given year, and an additional 45,000 people are in a housing crisis./2007/The 2004 single year poverty rate estimate for Indiana is 11.6%. For children, the poverty rate in 2004 was 18.5%, higher than the national average of 17.8%.//2007//
/2008/The Kids Count Data Book by the Annie E. Casey Foundation shows 12% of the population in poverty with 20% of children under age 6 in poverty in 2005.//2008//
Source:
http://www.aecf.org/kidscount/sld/profile_results.jsp?r=16&d=1&c=1&n=1&p=5&x=169&y=10
Target = Children under age 6

Indiana requires impoverished families to pay income tax. Currently, families begin paying state income tax when they earn 76% of the federal poverty level. This tax threshold could be lowered

to 36% if the state Earned Income Tax Credit is not upheld for 2005. Specifics can be found at the Center on Budget and Policy Priorities - http://www.cbpp.org/4-12-05sfp-in.pdf /2007/Indiana's threshold for families paying the state income tax remained the same in 2005, but the poverty level was increased, with the effect that families now begin paying state income tax when they earn 74% of the federal poverty level.//2007//

The Robert Wood Johnson Foundation (RWJF) used data collected by the Centers for Disease Control and Prevention to estimate that in 2003, there were more than 600,000 (16.3%) uninsured adults ages 18 to 64 in Indiana. The U.S. Census estimates the national uninsured rate at 13.9%. In 2003, 161,815 (9.6%) children in Indiana under age 19 were uninsured./2007/RWJF estimated that in 2004 14.2% of all Indiana residents did not have any insurance. For children under the age of 18, the uninsured rate is 8.9%. //2007//
/2008/U.S. Census data shows that in 2005 14.2% of all Indiana residents did not have any insurance and 9.7% of children under the age 18 were uninsured. In April the Indiana Legislature approved House Enrollment Act 1678 on health coverage for uninsured Hoosiers. The Act would raise the state's cigarette tax by 44 cents to help fund health coverage for 132,000 uninsured Hoosiers. The governor signed this legislation. //2008//

Indiana ranks 46th for the percent age 25+ with BS, BA or graduate degrees at 21.1%. The state's economy still is based heavily on manufacturing. College graduates tend to leave the state for better pay. Indiana University is proposing a 4.9% tuition increase for undergraduate courses. The increase would cost undergraduates as much as $335 more in tuition and mandatory fees per semester. Purdue University is considering a 6% hike that would cost undergrads $366 more./2007/Latest estimates show a marked improvement in college graduation rates for Hoosiers age 25 and older. With a rate of 26.3% in 2002, Indiana ranked 34th. Indiana University approved the 4.9% tuition fee increase in 2005. Purdue University adopted the proposed 6% hike.//2007//
/2008/The Indiana Department of Education revised the formula for determining high school graduation rates which show only 75.5% of high school students graduate statewide. The educational attainment rate for a Bachelors Degree or higher for Hoosiers age 25 and older was 21.1% in 2004.//2008//

In 2004, State Police alone arrested more than 1,200 people as a result of methamphetamine lab busts -- which affected the lives of at least 219 children, most of them related to the arrested adults and subsequently, thrust into the state's child protection system. Last year, state officials estimated, more than 30 percent of neglect and abuse cases they handled were in some way connected to methamphetamine abuse or manufacture. New legislation requires cold medications containing components used in methamphetamine manufacture to be controlled by pharmacists from behind the counter./2007/Methamphetamine lab seizures in Indiana decreased from 1549 in 2004 to 1300 labs seized in 2005.//2007//
/2008/ Heroin use is increasing in Indiana, State Police will have investigated about 700 cases in 2006, about 3 times the total in 2004.//2008//
Source:
http://chestertontribune.com/PoliceFireEmergency/heroin_becoming_more_prevalent_i.htm
Target = 700 heroin cases

The Environmental Integrity Project named 12 Indiana coal-burning power plants, including one on the Southside of Indianapolis, among the 50 "dirtiest" in the country for producing health-damaging pollutants. The report underscores the potential health threat from power company smokestacks throughout Indiana. With one exception, the Indiana companies did not challenge the group's findings. The report, "Dirty Kilowatts: America's Most Polluting Power Plants," compiled data from the U.S. Environmental Protection Agency and the Department of Energy's Energy Information Administration for sulfur dioxide, nitrogen oxides, mercury and carbon dioxide. The mercury data were from 2002, and the rest of the information came from 2004. See http://www.environmentalintegrity.org/pub315.cfm
/2008/In 2006, Indiana was identified as having 5 of the "dirtiest" coal-burning power plants

in the nation -- more than any other state.//2008//
Source: http://www.environmentalintegrity.org/pub385.cfm
Target = Indiana (5);

According to the Indianapolis Star, April 15, 2005, Marion County's child welfare program faces a $20 million deficit and will likely have to borrow money this year to feed and clothe more than 3,000 children. An increase in the number of children needing care has driven costs up. New children sent into the system by the juvenile court in 2004 had increased to more than 2,000, up from a figure of 540 in 1996. The Office of Family and Children is largely paid for by county taxes but is managed by the state, leaving county elected officials holding the purse strings with no oversight on spending and little incentive to increase funding. Similar structural problems statewide played a role in the development of a separate Department of Child Services at the state level distinct from the rest of state social services.

Planned Parenthood of Indiana sued Attorney General Steve Carter to stop his office from seizing the medical records of 73 low-income Medicaid patients who have sought reproductive services. None of the records involves abortions. The Attorney General's Medicaid Fraud Control Unit was investigating an incident report or complaint alleging failure to report statutory rape. The eight records already turned over are of 12- and 13-year-old patients. In Indiana, anyone under age 14 who is sexually active is considered to be a victim of rape. Planned Parenthood maintains its personnel follow the law and report those patients to child protective services for further review. The Indiana Civil Liberties Union filed the lawsuit on behalf of Planned Parenthood. The record seizure has been postponed by court injunction./2007/A decision is pending in the Indiana Court of Appeals.//2007//
/2008/The Attorney General has decided not to appeal the case further, with the result that the records in question will not be turned over to the Attorney General.//2008//
Source: http://www.ppin.org/news.aspx?NewsID=44
Target = Sept. 22 decision

Signed by Governor Daniels, new 2005 State Laws:
*Create a new cabinet level Department of Child Services to provide child welfare and protective services. This department takes over these duties from the Family and Social Services Administration (FSSA)
*Require all counties of Indiana to observe Daylight Savings Time beginning 2006. Since 1971, most of Indiana has not observed DST, while the counties nearest Chicago synchronized with Chicago
*Require FSSA Department of Mental Health, Indiana Department of Child Services and Indiana Department of Education to develop a plan for children's emotional and developmental health
*Require FSSA Office of Medicaid Policy and Planning to seek a family planning waiver for Medicaid
*Create a state Department of Homeland Security to take over duties from several state agencies that will be abolished or re-assigned
*Provide health coverage for the surviving spouse and dependent children of active Indiana State Police officers killed in the line of duty
*Increase the penalty for voyeurism from a misdemeanor to a felony if the offender has a previous conviction for voyeurism
*Start a "Code Adam" program to help find missing children in certain state buildings. The system would notify state employees about a missing child in the building, and employees could then stop normal work to help search for the child and monitor exits
*Make it a misdemeanor for someone to intentionally provide dental hygienist services without a license
*Require most voters to show State issued or military ID to cast a valid vote (Indiana's ACLU has filed suit to contest this law on behalf of homeless and low-income residents)
*Create the Office of Inspector General, reporting to the Governor, to investigate fraud and abuse in state government and tighten State ethics rules

*Restrict the sale of cold medicines that contain chemicals that can be used to create methamphetamines
*Raise speed limits on most state highways to 60mph and Interstate highways to 70mph
*Require child care homes that receive a voucher payment and licensed child care homes to receive training concerning safe sleeping practices for children and require the Division of Family and Children to provide or approve training concerning safe sleeping practices for children
*Require ISDH to adopt rules for the case management of children with lead poisoning and allow ISDH to coordinate lead poisoning outreach programs with social service organizations and require OMPP to develop measures to evaluate Medicaid managed care organizations in screening children for lead poisoning, a system to maintain the results and a performance incentive program
*Require ISDH to develop storm safety guidelines to schools and make them available to child care centers, day care centers and public parks and require Department of Education to distribute the guidelines to all public and non-public schools in Indiana.
/2007/New state laws signed by Governor Daniels effective July 1, 2006:
*Require injuries resulting from fireworks or pyrotechnics be reported to ISDH
*Create sexual assault standards and a certification board to certify sexual assault victim advocates, transfer control of the new sexual assault victim's account from ISDH to the new board, and repeal the sexual assault victim's assistance fund
*Require ISDH to study the use of drugs, alcohol, and tobacco by pregnant women and submit a report to the legislative council and health finance commission by Oct. 1, 2006
*Allow employers to implement financial incentives related to employer provided health benefits to reduce employee tobacco use
*Require each school board to establish a coordinated school health advisory council to develop a local wellness policy that complies with certain federal requirements
*Specify a physician's duty to monitor bariatric surgery patients for 5 years, establish topics that must be discussed prior to surgery, specify the information that must be reported to the ISDH, and require 6 months of supervised nonsurgical treatment before health insurance, state health care plan or health maintenance organization are required to cover surgical treatment
*Establish the ISDH as the lead agency for the development and implementation of a statewide trauma system and adopt rules regarding the system
*Allow the Office of Medicaid Policy and Planning to apply for federal approval to amend the state Medicaid plan to include a pay-in option
*Require certain licensed professionals to provide the professional licensing agency or the ISDH with their Social Security numbers
*Create a water shortage task force to develop and implement an updated water shortage plan and address other surface and ground water issues.//2007//
/2008/New state laws passed by the legislature that the Governor is expected to sign for 2007:
****House Enrolled Act 1001 which provides funding for K-12 education, Medicaid, transportation and other state services. This Act will devote $92 million to help school districts launch full-day kindergarten.***
**** House Enrolled Act 1678 would raise the state's cigarette tax by 44 cents to help fund health coverage for 132,000 uninsured Hoosiers. It also provides for a tax credit related to small employer qualified wellness programs, increase Medicaid coverage for pregnant women to 200% FPL allows for presumptive eligibility for ambulatory pregnant women and raises eligibility for children to 300% FPL.***
****House Enrolled Act 1033 will require all new mobile homes to come equipped with emergency weather radios.***
****House Enrolled Act 1548 would require ISDH to coordinate the donation, collection, and storage of umbilical cord blood from newborns***
****Senate Enrolled Act 327 requires written notice for the parents of sixth grade girls, informing them about the connection between cervical cancer and the human papillomavirus. Also informs about vaccinations***
****House Enrolled Act 1237 will require nearly all motorists in the state to wear seat belts, including those riding in back seats, pickup trucks and SUVs***

Senate Enrolled Act 9 will let local governments restrict or ban the use of fireworks except on New Year's Eve, New Year's Day and an 11 day period around July 4
House Enrollment Act 1027 will tie Indiana's minimum wage to the federal minimum wage
House Bill 1116 which requires emergency procedures training for teachers. Teachers will have training in cardiopulmonary resuscitation (CPR), removing obstructions to a person's airway, and the Heimlich maneuver before obtaining an initial license as a teacher
Senate Bill 0207 Requires the state department of health, in regards to Medical adverse events reporting, to enter into an agreement with an agency to collect, analyze, interpret, and disseminate findings on a statewide basis until June 30, 2010, regarding patient safety
House Bill 1457 reauthorizes the Indiana Birth Defects and Problem registry for 10 more years and establishes the prenatal substance use commission to develop and recommend a coordinated plan to improve early intervention and treatment for pregnant women who abuse alcohol or drugs or use tobacco. It also requires the first meeting of the commission shall be convened before October 15, 2007.//2008//

Governor Daniels formed a Hoosier Health Care Cabinet, a group of state employees with backgrounds in health care delivery and financing. Cabinet members include Family and Social Services Administration (FSSA) Secretary Mitch Roob, State Health Deputy Commissioner Mary Hill, FSSA CFO Dick Rhoad, FSSA Director of Health Policy for Medicaid Jeanne LaBrecque and FSSA Chief of Staff Anne Murphy. The direction for this group is not yet available./2007/ The Health Cabinet has overseen several projects such as: integration of public health principles into the delivery of quality healthcare to Medicaid recipients; systems evaluation to improve lead screening rates; rebuilding the service delivery model for children with developmental disabilities through coordination of education, public health, and human services resources; statewide leadership on the development of interactive electronic health information capabilities, with emphasis on security and privacy issues, as well as clinical messaging; and Removing regulatory impediments to the development of local traumatic brain injury facilities, as well as respite care facilities for families with disabled children.//2007//

Gov. Daniels announced a new statewide program to help Hoosiers find and apply for programs providing free or lower cost prescription drugs. The program will expand on a privately run program in southern Indiana. The Evansville program allows people to access low-cost prescription drug programs by inputting basic information into a computer web site. The system searches for the best discount program and provides the application. Concerned that only one in 10 people who are eligible for such programs take advantage of them, the governor hopes "Rx for Indiana" will bolster those numbers. "Rx for Indiana" will offer information on more than 2,400 drugs and more than 300 discount programs, including those run by pharmaceutical companies and the state. The site, www.rxforindiana.org, includes a Spanish-language version and a toll-free number, (877) 793-0765, which has Spanish-speaking operators to help guide the individual through the application process./2007/ Over 98,000 Indiana residents accessed the Rx for Indiana website with 74% initially qualifying for assistance.//2007//

ISDH CURRENT PRIORITIES and INITIATIVES
Indiana State Department of Health (ISDH) is charged with central planning and regulatory development and administration for all health care delivery in Indiana and with improving the overall health of the population through education, advocacy and program support. Indiana's 94 local health departments operate independently from ISDH as arms of local or county government. Many local health departments receive grants from ISDH Maternal and Children's Special Health Care (MCSHC), the division charged with carrying out the goals of Title V of the Social Security Act.

Indiana has a mix of for-profit and not-for-profit hospitals and a broad array of local clinics, many of which are also ISDH MCSHC grantees. Additionally, MCSHC contracts with a number of consulting groups, media services organizations and universities to provide planning, educational and public information programs to advance maternal and child health in the state.

STATE HEALTH PERFORMANCE PLAN
Indiana State Department of Health (ISDH) issued the 2005 State Health Performance Plan (SHPP) that set priorities in two areas: Health Status and Health Systems. Health Status Goals: Chronic Disease (heart disease, cancer, diabetes, asthma, hypertension), Infant mortality and prematurity, Minority health disparities, and Obesity. Health Systems Goals: Access to primary care (particularly for underserved populations), Health care quality (Regulation, Promoting evidenced-based medicine and best practices) and Public health infrastructure (Staffing {number, skills/training, age}, Budgets, Communication and Information Technology).

The following sections from the SHPP outline priorities for which MCSHC is partly or primarily responsible.

The SHPP identifies baseline chronic disease levels in Indiana and sets goals for 2010 in relation to the Healthy People 2010 goals. These goals include both total disease indicators and weighted indicators for Black and Hispanic populations. SHPP notes a 2002 baseline of 1.3 asthma-related deaths per 100,000 among children age 0-14 and a goal of 1/100,000 by 2010. For Black children, the 2000 baseline is 6.3 deaths per 100,000 with a 2010 goal of 3.8/100,000. ISDH Priority Goal: Reduce asthma morbidity and mortality rates in Indiana.

SHPP shows a 2002 baseline of 7.6 infant deaths in 1,000 (6.5 white, 15.6 black), 9.4% prematurity (9% white, 12.5% black) and 7.6% low birth weight (6.9% white, 12.9% black). ISDH Priority Goal: Decrease Indiana's infant mortality and prematurity rates.
/2008/ 2003 infant mortality rate was 7.3 per 1,000 (6.5% white, 14.2% black) //2008//

Obesity in Indiana is epidemic. SHPP notes 61.3% of adults are overweight and 26% obese (2003). Among high school students, those rates are 25.7% and 14.2%. ISDH Priority Goal: Decrease the percentage of overweight and obese persons in Indiana.

/2007/ In July of 2005, Governor Daniels initiated INShape Indiana, a statewide web-based health initiative. INShape Indiana is designed to help Hoosiers make healthy lifestyle choices. The INShape Indiana website includes a clearinghouse of information on programs, activities, and events from all over the state related to nutrition, physical activity, and tobacco cessation, a bi-weekly tracking mechanism that allows individuals to monitor their progress towards a healthier lifestyle, and the opportunity to celebrate individual and group success stories and serve as healthy role models for other Hoosiers. INShape Indiana promotes personal responsibility for health behaviors while promoting good nutrition, smoking cessation and increased physical activity. All MCSHC grantees are required to incorporate activities and information about INShape Indiana into their project activities.//2007//

Agency Priority Goals are to: Increase the number of minorities entering the field of public health; develop a more culturally competent workforce; enhance access to primary care; promote and improve the quality of health care provided by Indiana health care providers; and improve Indiana's public health care infrastructure./2007/New ISDH agency priority goals which all grantees must include are: Data driven efforts for both health conditions and health systems initiatives that are effective, efficient, provide timely data collection, and ensure evidence based results; Promote INShape Indiana -- this includes agency wide participation and engagement of all components of communities and collaborative partners; Integration of medical care with public health: Preparedness -- Planning and training for poised and effective response to threats that cannot be prevented.//2007//

TITLE V PRIORITY SELECTION
The MCSHC statewide needs assessment is the first step in determining priorities, identifying emerging issues and planning the development and delivery of Title V services.

ISDH MCSHC contracted with an epidemiologist to pull together information from 10 regional epidemiologists in the State's Public Health Preparedness program, along with other statistical information and data generated by other consultant contractors to create the 2006-2010 MCSHC Needs Assessment. Below is an overview of those findings not previously detailed in the SHPP above.

Rates of overweight and obesity increased in Indiana from 1999 to 2002, mirroring national trends. Currently, more than 60% of Indiana's population is overweight, with more than 25% obese. These rates are slightly higher than national averages.

Only 42.8% of Indiana women were normal weight before pregnancy in 2001. According to the CDC Pregnancy Nutrition Surveillance System of pregnant women participating in WIC, 13.4% were overweight, 29.2% were very overweight, 9.7% were underweight and 4.9% were very underweight.

Pregnancy rates among Indiana women age 20 and less decreased from 3.2% in 1999 to 2.6% in 2002. Black teenagers are 2.5 times more likely to become pregnant than white teenagers.
/2008/ The percent of births to women less than age 20 was 11% in 2003.//2008//

Between 1999 and 2001, the number of induced pregnancy terminations in Indiana decreased by 1.94% to a total number of 11,281 pregnancy terminations in 2001.
/2008/ There were 10,036 induced pregnancy terminations in Indiana in 2004.//2008//

Indiana's 2002 birth rate was 1.38%, below the national average of 1.39%./2007/Indiana's 2003 birth rate was 1.40%, below the national average of 1.41%//2007//

In 2002, there were 40 infant deaths due to SIDS in Indiana resulting in a SIDS age specific death rate of 47 per 100,000 live births. The Healthy People 2010 goal is to reduce the SIDS mortality rate to 30 per 100,000 live births. In whites SIDS is the third leading cause of death with age specific death rate of 45.3 per 100,000 live births (n=33) where as in blacks SIDS deaths ranked 5th (n=14) after short gestation/low birth weight disorders, congenital defects, accidents, and maternal pregnancy complications.
/2008/In 2004, there were 42 infant deaths due to SIDS, resulting in a rate of .48 per 1000 live births. Of the 42 infants, 32 were white infants and 8 were black infants.//2008//

At 19.1% in 2002, Indiana had the 6th highest maternal smoking rate among 49 reporting states. This rate is higher among whites than blacks. While Indiana has seen a steady decrease in this rate, it is unlikely the state will reach the HP2010 goal of no more than 1%./2007/In 2003 the maternal smoking rate decreased to 18.5%.//2007//

However, results from the 2004 Indiana Youth Tobacco Survey show that the percentage of children who smoked in grades 6 through 8 dropped to 7.8% from 9.8% in 2000. In grades 9 through 12, the percentage of smokers dropped to 21% from 32% in 2000. Nationally, 22.3% of high school students and 8.1% of middle school students said they had smoked cigarettes last year, according to CDC.

Indiana's infant mortality rate of 0.76% (7.6/1000 live births) in 2002 was higher than the national average of 7/1000. Of the total 649 infant deaths in Indiana in 2002, 68% occurred during the first 28 days of life. The remaining 32% were between 28 and 365 days. White infant mortality was 6.5 while black infant mortality was 15.6 (2.4 times the rate for white infants)./2007/In 2003 the infant mortality rate was 7.3/1000 live births, higher than the national average of 6.85. White infant mortality remained at 6.5, while black infant mortality decreased to 14.2.//2007//

Racial and income-based disparities exist in nearly all health statistics with low-income women and women with less than high school diploma or GED experiencing higher rates of asthma, obesity, diabetes and heart disease and experiencing these problems at earlier ages. Despite concerted efforts, the black infant mortality rate remained about 2.5 times higher than the white in Indiana. The vast majority - 89% of Indiana's population is white. However, minority populations are growing faster than the white population with the highest growth rate (62%) among Asians

According to the 2003 US National Immunization Survey, Indiana has remained above the national average for percentage of children vaccinated for most individual antigens and all vaccination series.

In 2002, 15.7% of Indiana households had at least one child with asthma. According to the Office of Medicaid Policy and Planning (OMPP), of 23,161 children, age 0-17, enrolled in Medicaid in 2003, 10% had an emergency room visit with principal diagnosis of asthma and 4% were hospitalized for asthma. Asthma is the most common diagnosis among children enrolled in CSHCS.

Between 1999 and 2003, Allen, Clinton, Elkhart, Lake, Marion, St Joseph and Wayne Counties had the highest number of children with elevated blood lead levels. Except Elkhart, these counties have percentages of children living below poverty well above the state average of 14.4%. In 2003, the Childhood Lead Poisoning Program indicated that 2.9% of 31,413 children screened had elevated blood levels./2007/Currently only Marion County requires the testing of a home where a child has been lead poisoned. No county in Indiana requires testing of housing units built before 1950 prior to being rented.//2007//

Indiana Attorney General, Stephen Carter, has provided a letter of support to all local health departments and cities applying for lead poisoning prevention and abatement grants indicating an aggressive stance to require landlords to reduce lead paint hazards and pursuing legal expenses in cases requiring court action.

Use of protective dental sealants among Indiana children increased by 13.5% from 1999-2003. Further data indicates sealants are increasing among all races. At 47.2% in 2002, Indiana was very close to the HP 2010 goal of 50% of children receiving protective dental sealants./2007/ 46% of third grade children had at least one permanent molar tooth treated with a protective sealant in 2005.//2007//

The leading causes in Indiana's 2002 adolescent death rate of 83.2/100,000 were unintentional injury 43.9%, homicide 14.5% and suicide, 13%. Homicide was the leading cause of death for black adolescents in Indiana, accounting for more of the 147.65/100,000 death rate than all other causes combined.
/2008/ In 2004, Homicide claimed 91 Indiana citizens ages 15-24; of those, 59 were black individuals and 32 were white. Suicide claimed another 89, with blacks accounting for 8 deaths and whites for 77.//2008//

From 1999 - 2003, reported cases of child abuse fluctuate between 3,620 and 4,415. Neglect cases rose to 15,634 in 2000 and tapered to 12,308 in 2003. However, a number of high profile cases during the election of 2004 have placed attention on this issue. Governor Daniels campaigned with a promise to separate child protective services from FSSA./2007/In 2004 there were 24,995 reports of abuse and/or neglect with 57 substantiated fatalities. The Department of Child Services (DCS) was established in January 2005 by an executive order of the Governor to better care for children by providing more direct attention and oversight in two critical areas: protection of children and child support enforcement. The DCS protects children and strengthens families through services that focus on family support and preservation. The department administers child support, child protection, adoption and foster care throughout the state of Indiana.//2007//

Self-reported monthly alcohol use among high school seniors has dropped from 51.7% to 46.1% from 1999-2003, mirroring national averages. Marijuana and psychedelic consumption has also dropped. Cocaine use remained at 2.5% among Indiana adolescents in 2003, above the national average. Inhalant use also increased among younger adolescents./2007/The 2005 Youth Risk Behavior Surveillance System showed an increase from 12.9% in 2003 to 14.1% in 2005 for inhalant use. Teen age alcohol consumption within the past 30 days decreased to 41.4% in 2005 from 44.9% in 2003.//2007//

DEVELOPMENT OF PRIORITIES
ISDH MCSHC determines priorities based on the following considerations: health and capacity data; priority survey data; state health plan; MCH objectives; and what other organizations are doing statewide. Priorities must meet the following criteria: ISDH must be able to address the problem; solutions must be feasible; resources must be available; and the problem must fit with purposes of Title V, Healthy People 2010, and the Governor's priorities. ISDH MCSHC addresses priorities through commitment of funding, staff time and working to focus the efforts of ISDH and other agencies on those priorities. MCSHC continuously evaluates programs and monitors emerging issues through staff effort and contracts with consultants to conduct needs assessment, project evaluation, public hearings, focus groups, surveys and analysis.
/2007/MCSHC has developed a Priority Health Need for the MCH population for 2006-2011 to increase the rate of maternal smoking cessation and reduce the rates of domestic violence to women and children, child abuse and injury in Indiana. In 2003, domestic violence, caregiving stress and poverty were the top 3 challenges Central Indiana women faced. MCHSC will contract with the Indiana Coalition Against Domestic Violence to conduct a series of workshops entitled "Improving the Healthcare Response to Domestic Violence in Indiana". Indiana's infant death rate has ranked near the top nationally over the 1999-2003 period, with an infant injury related death rate nearly twice the national average. During 2003 Indiana ranked first in the nation in unintentional suffocation deaths of infants less than 1 year of age with a rate of 46.47 per 100,000. An Infant Death Workgroup of state agencies, hospitals and other child protection organizations has been formed to gather and evaluate data, and eventually make recommendations to strengthen current programs or establish needed initiatives to decrease Indiana's infant injury related mortality rates. MCSHC has developed a evaluation system enabling efforts to be focused on target counties.//2007//

B. Agency Capacity

B. Agency Capacity

In the State of Indiana, the Title V program is administered through the Maternal & Children's Special Health Care Services division (MCSHC) of the Indiana State Department of Health (ISDH) Human Health Services Commission. MCSHC manages a number of funds from federal and state sources including Title V for an estimated total allocation of $35,832,070 for FY 2005
.

MCSHC provides funding for projects in all levels of the MCH Pyramid. MCSHC staff is directly involved in infrastructure building within ISDH, among other state agencies, and among non-state agencies. Through the Title V Block Grant Federal/State Partnership, MCSHC funds agencies to provide direct medical services for women of childbearing age, pregnant women, infants, and children and acts as payer of last resort for primary and specialty care for children with special health care needs (CSHCN). These grantees/contractors also provide enabling services (such as care coordination) to prenatal clients and to families of CSHCN. MCSHC also creates and implements population-based education on topics like adolescent pregnancy prevention. See Narrative Part C for a detailed list.

MCSHC staff interface with state physician and dental organizations, Office of Medicaid Policy and Planning (OMPP) and other managed care insurers (especially those working with low-

income populations), laboratories that run the newborn screens and meconium screens, not-for-profit groups that are working toward the same improved health outcomes as ISDH MCSHC and other state agencies to coordinate and assure that quality health care is available. MCSHC also monitors statistics for Indiana's Health Status Indicators (HSI) and health outcomes and shares this information with the public.

ISDH is the statutory authority for Maternal and Child Health (Title V) programs, receiving state funds to match Title V funding. By statute, ISDH also operates through MCSHC the following state programs: Children's Special Health Care Services (CSHCS), Newborn Screening and Follow-up, which includes Sickle Cell Education, Screening for Drug Afflicted Babies, Adolescent Pregnancy Prevention, follow-up and education, Universal Newborn Hearing Screening, and the Indiana Birth Defects and Problems Registry.

MCSHC provides information, referral and assistance to Indiana citizens statewide through the Indiana Family Helpline (IFHL). The IFHL helps families and individuals access social and health services for mothers, children and families through telephone and e-mail contact. The IFHL has bilingual employees, uses the ATT Language Line, as well as a TTY line to better serve the hearing impaired. The IFHL is obtaining Alliance of Information & Referral Services accreditation to qualify to become a 211 Information and Referral (I&R) call center for some Indiana counties.

Genomics / Newborn Screening Program goals include increasing public and professional awareness of genetics, assuring access to services, enhancing genetic data collection statewide and improving the quality of the birth defects surveillance system. MCSHC funded projects offer genetic testing, evaluation and counseling, and prenatal diagnosis through support of five regional genetics projects that sponsor clinics in thirteen sites. The Genomics Program Director offers consultation to these and nine (seven non-funded and two state funded) additional Genetics Centers/Programs in Indiana. Genomics also facilitates the Folic Acid Initiative, sponsored by Title V and WIC, a population-based education effort and "Genetics and Your Practice," sponsored by MCSHC and March of Dimes, a professional training opportunity.

MCSHC capacity to expand data integration and ISDH program integration was enhanced with receipt of the Genetics Implementation Grant (GIG) in September 2002. Through this grant, the MCSHC Genomics program assists with newborn screening, birth defect and other chronic disease data integration, as well as establishment of medical home, folic acid and genetics education for professionals and consumers. The scope of MCSHC Genomics includes adult chronic diseases and general genetics education and bridges the perinatal and child health services. The Genomics program strives to increase the awareness and understanding of genetic conditions and ensure that all of the approximate 5,000 infants born in Indiana each year with birth defects or genetic conditions have access to genetic services./2007/GIG funding has concluded, but most of the programs initiated with GIG funds have been continued with other resources under the MCSHC Genomics and Newborn Screening Program. A one year extension at no additional cost has been requested to continue Medical Home training and to complete the Indiana Birth Defects and Problems Registry (IBDPR).//2007//

Genomics collaborates and coordinates with regional genetic centers (both state sponsored and private providers of genetic services), as well as local agencies, individual providers, hospitals, health departments, the Indiana Perinatal Network (IPN), and the Indiana Chapter of the March of Dimes and builds public health genetics capacity within ISDH. Genomics also houses the Indiana Birth Defects and Problems Registry (IBDPR).

1. Pregnant Women, Mothers and Infants
MCSHC provides the Free Pregnancy Test program, a population-based enabling service intervention to reduce infant mortality and encourage women to access early prenatal care. The program provides agencies serving women of childbearing age free pregnancy tests to use as an outreach service for hard-to-reach clientele. The goals of the program include: (1) helping pregnant women obtain early prenatal care, Hoosier Healthwise, and WIC; (2) encouraging

women to obtain a high school diploma or GED; (3) decreasing infant mortality and morbidity and the incidence of low birthweight; (4) assisting local communities and grantees to assess for service gaps for planning of future programs; and (5) assisting non-pregnant adolescent women into the health care system through Hoosier Healthwise enrollment. Through this program, MCSHC has developed an infrastructure of agencies that focus on women of childbearing women age and has created an ongoing database for assessment and evaluation of services offered and needed by sexually active, low-income women. Currently, the Free Pregnancy Test program is available in 63 counties.

MCSHC provides preventive, primary care, and enabling services for pregnant women, mothers and infants including prenatal health care services through grants to 13 agencies to promote direct prenatal medical services, as well as funding 23 prenatal care coordination projects. The primary objective of these grants is to decrease infant mortality and low birthweight by providing quality, comprehensive, holistic health care to low-income pregnant women in community settings. MCSHC funded prenatal care coordination programs to develop and coordinate access to community-based health care services for pregnant women and their families at risk for poor pregnancy outcomes. Prenatal care coordination grantees provide outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women and some non-Medicaid clients. The direct medical and enabling services target pregnant women with low incomes and pregnant women who are high-risk because they reside in medically underserved areas. MCSHC staff also trains and certifies community health workers to assist prenatal care coordinators. MCSHC collects, analyzes and disseminates perinatal outcomes to communities to ensure that the planning and delivery of perinatal heath care services meet the needs of the population.

MCSHC develops and enhances capacity to promote and protect the health of all mothers, children and families through Thirteen family care coordination projects that provide enabling services to facilitate a seamless delivery of services for mother and children through outreach, assessment, care planning, advocacy, referral, education and counseling on health behavior risk reduction during both clinic and home visits with the family. Goals are to improve utilization of EPSDT services, immunization service, and primary care providers, and to empower families with education and support to access health, education, and social services they need.

MCSHC provides Family Planning and Women's Health Services through 11 local grantee agencies. The Indiana Family Health Council (Indiana's Title X agency) is contracted to provide clinic monitoring and standards of care for these grantees./2007/Begining in 2007, if approved, MCHSC will provide all Title V Family Planning through IFHC, blending Title V and Title X Family Planning programs.//2007//

The Prenatal Substance Use Prevention Program (PSUPP) is funded through a grant from FSSA Division of Mental Health and Addiction (DMHA) and supplemented with Title V Federal -- State Block Grant Partnership and funds from Indiana Tobacco Prevention and Cessation (ITPC). PSUPP works to prevent birth defects, low birthweight, premature births, and other problems associated with prenatal substance use. There are three primary objectives: (1) identify high risk, chemically dependent pregnant women, provide perinatal addiction prevention education, promote abstinence, provide referrals for treatment, and follow-up; (2) facilitate training and education for professionals and paraprofessionals who do not provide substance abuse treatment, but do work with women of childbearing age, on how to identify high risk, chemically dependent women; and (3) provide public education on the possible hazards to a fetus when alcohol, tobacco, and other drugs are used during pregnancy. Free posters, brochures, and other materials are available upon request through the Indiana Family Helpline. MCSHC supports enabling services for drug use cessation through 15 grantees. In addition, the PSUPP Director builds professional capacity through professional training. This program also interfaces with smoking cessation efforts with prenatal services and ISDH by providing public education./2007/MCHSC continues to support enabling services for alcohol, tobacco, and drug use cessation through Fifteen PSUPP grantees.//2007//

MCSHC Newborn Screening facilitates newborn screening and follow-up programs including metabolic screening, sickle cell follow-up, hearing screening programs, and meconium screening to test for drug-afflicted babies. Newborn screening is performed on every infant born in Indiana. The program is funded by a $62.50 fee for each infant screened collected from each birthing facility by the central testing lab under contract with ISDH MCSHC. The contractor remits $30.00 of each fee to ISDH and retains the balance to pay for laboratory and collection services. Indiana University Medical Center Newborn Screening Laboratory (IU NBS Lab) is the laboratory designated by the Indiana State Department (ISDH) for processing specimens.

A blood test (by heel-stick) is done on all infants shortly after birth to test for 39 metabolic or genetic disorders. Follow-up is done to obtain repeat screens on all abnormal and unsatisfactory screens. If further follow-up is needed, the Newborn Screening Section requests assistance from the local Public Health Nurse. Infants that have a positive screen for one of the designated genetic disorders are referred to the Metabolic Specialist or the Endocrinologist at the Indiana University Medical Center. The ISDH NBS Section works collaboratively with IU NBS Lab, Sickle Cell Program, and the Genomics Program to ensure follow-up and treatment for all infants diagnosed with one of the designated disorders.

The MCSHC Early Hearing Detection and Intervention (EHDI) program screens all infants born in Indiana for possible hearing impairments. Those found with hearing impairments receive early intervention and follow-up services. UNHS coordinates with Indiana First Steps Early Intervention Services, hospitals, providers, and other agencies to provide statewide implementation. The goals for infants that do not pass the hearing screening are to receive audiology evaluations by three months of age and to be enrolled in an appropriate intervention program by six months of age. MCSHC EHDI collects comprehensive monthly data via Monthly Summary Reports (MSR) from each of the 108 birthing facilities throughout the state of Indiana and is developing a web-based electronic reporting system to enhance hospitals, audiologists and early intervention coordinators in ensuring timely and accurate evaluation and follow up treatment. The program educates the public, including parents and primary care physicians of the importance of early detection and intervention and works in conjunction with the Indiana School for the Deaf to promote awareness and parent participation in the program.

MCSHC funds programs for Sickle Cell and Other Hemoglobinopathies. This program provides penicillin, education, care coordination, and counseling for sickle cell clients in the state. There are four regional sites for the care coordination. The Indiana Hemophilia and Thrombosis Center, Inc. (IHTC) also provides sickle cell education to families statewide. This program provides education and consultation to primary and hospital emergency room providers about current therapy for sickle cell disease complications and educational materials to health care providers and patients' families. MCSHC supports the Parents Empowering Parents (PEP) program to assist families living with children with Sickle Cell Disease with parenting./2007/There are 5 regional sites for the care coordination.//2007//

MCSHC also contracts with IHTC to provide outreach to Amish persons with bleeding disorders. The program provides home visiting, health care services, an annual health clinic and factor concentrate to those affected.

Indiana Birth Defects and Problems Registry (IBDPR) is a population-based surveillance system that seeks to promote fetal, infant, and child health, in order to prevent birth defects and childhood developmental disabilities, and to enhance the quality of life of affected Indiana residents. IBDPR collects data on all children in Indiana from birth to age three with congenital anomalies or disabling conditions and up to age five for children with fetal alcohol syndrome and autism. The information provided by the registry has the potential to uncover the environmental causes of defects, thus preventing future cases./2007/IBDPR sent 2003 data to Birth Defects Research, Part A, Clinical and Molecular Teratology, 2006 Congenital Malformation Surveillance Report, showing increased IBDPR capability. IBDPR is a separate program under the Genomics and Newborn Screening Program.//2007//

The data collected for IBDPR is used to (1) detect trends in birth defects and suggest areas for further study, (2) address community concerns about the environmental effects on birth outcomes, (3) evaluate education, screening, and prevention programs and (4) establish efficient referral systems that provide special services for the children with identified birth defects and their families.

Indiana State Law requires a screening test for possible drug affliction in certain newborns. Hospitals and physicians are required to submit a meconium specimen for every infant who meets the selection criteria to test for Amphetamines, Cannabinoids, Cocaine and Opiates. MCSHC contracts with a central lab to provide this screening for the state. MCSHC keeps the data from this program but does not do tracking. Local hospitals and the physicians are responsible to refer the mothers and infants for appropriate treatment, social services and early intervention./2007/Due to newly enacted legislation, MCSHC is conducting a study of the impact of alcohol, drugs, and tobacco use among pregnant women, and available services and making recommendations for improved services. The report will have input from other partners and is due to legislators by October 1, 2006.//2007//

2. Children
MCSHC provides preventive and primary care for children through 15 grants to agencies that provide direct medical services and enabling services to children and 6 adolescent health care programs. Many of these grantees are community health centers or are a part of a larger health care facility. They provide direct health care services and health and safety education. Using AAP guidelines and Bright Futures, MCSHC has developed Standards of Care for children 0-21 years of age.

MCSHC administers the Indiana Child Care Health Consultant Program (ICCHCP) through funding provided by FSSA from the Child Care Development Block Grant. MCSHC contracts with an outside entity to provide health education and technical assistance to licensed and unlicensed child care providers serving children 0-8 years of age. ICCHCP is contracted to hire and/or subcontract, educate and supervise qualified community based child care health consultants, identify out-of-home child care providers and develop an infrastructure linking them with child care health consultants in their local community and to identify, recruit, educate, certify, and provide oversight to professional child care health consultants and health advocates. ICCHCP collaborates with other health and safety providers in the state and with injury prevention efforts within ISDH.***//2008/In October 2007 the FSS Bureau of Child Care will integrate the Child Care Health Consultant Program into it's Quality Rating System. A Chief Nurse Consultant from MCSHC will continue to act as liaison with ISDH programs//2008//***

MCSHC is developing Early Childhood Comprehensive Services (ECCS) through a grant from MCHB to plan a coordinated, comprehensive, community-based system of services for young children from birth through age five and their families. ECCS is a collaborative process across public and private organizations. Core Partners include ISDH, FSSA, Indiana Department of Education (IDOE), Indiana Department of Corrections (IDOC), Indiana Department of Environmental Management (IDEM), the About Special Kids (ASK) program, formally known as Indiana Parent Information Network (IPIN), Indiana Association for the Education of Young Children, Indiana Head Start Association, and Riley Hospital for Children/Child Development Center. Additionally, five Subcommittees were formed and met to address the project's five focus areas which include: access to health insurance and a primary medical provider; mental health and socio-emotional development; early care and education; parent education; and family support. An application for implementation funding with a strategic plan has been submitted to MCHB./2007/The ECCS program is now known as Sunny Start: Healthy Bodies, Healthy Minds and is in the implementation phase.//2007// ***/2008/ The program continues to move forward with projects like marketing the expansion of the Early Childhood Meeting Place website (the information clearinghouse for families) and pilot testing Indiana WINS (the universal application). New projects include the development of an up-to-date developmental***

calendar to be used by families and providers which highlights important health and safety information such as infant and toddler's nutritional needs, oral health issues, and communication and gross motor development. When completed, this document will be posted on the Early Childhood Meeting Place website so that all Hoosiers will have on-line access.
Social and emotional development in young children continues to be a focus of Sunny Start. After receiving final approval from the Sunny Start Core Partners, the Social and Emotional Consensus Statement described above was finalized. Currently, Sunny Start committee members are developing a tool to be used in conjunction with the Consensus Statement that will help individuals assess the social and emotional competencies that their training addresses. Finally, Sunny Start is sponsoring a comprehensive one week Summer Institute in July, 2007 which will help mental health professionals in Indiana build skills in the area of social and emotional development in young children, infants and toddlers. The Core Partners and subcommittees continue to meet regularly with updates from these meetings posted on this website. //2008//

The Oral Health Director (OHD) which is now located in MCSHC Division and funded by Title V, focuses on education and prevention with a special emphasis on fluoridation. Oral Health staff provide technical assistance and surveillance to communities and schools with fluoridated water supplies. MCSHC supports the Oral Health community-based pit and fissure sealant program. This program's objectives include (1) promoting the use of sealants throughout Indiana and working toward the national health objective to have 50% of children with sealants by Year 2010, and (2) promoting the cooperation of Indiana dentists, dental hygienists, and dental assistants in community dental health programs. MCSHC continues to provide partial funding for the Indiana SEAL program, providing a mobile unit to bring these services to children across the state.

In addition to their fluoridation efforts, Oral Health is the investigative authority regarding universal precautions and infectious waste management issues as they pertain to delivery of oral health services; legislatively mandated to annually survey a percentage of Indiana licensed dentists as to the effectiveness of the routine biological testing of their autoclaves; promotes the P.A.N.D.A. program (Prevent Abuse and Neglect through Dental Awareness) by providing educational presentations to local dental societies and organizations throughout the state; and provides educational materials relative to Oro-facial Injury Prevention, as requested. Additionally, MCSHC funds a grantee to provide a dental clinic for Amish children in northern Indiana to provide dental care, achieve optimal fluoridation, and increase awareness of oral health and disease***./2008/ In Spring 2007 the Oral Health Program was moved under the purview of MCSHC. The Fluoridation Program was moved to the Division of Consumer Protection at ISDH. A state Oral Health Plan will be developed in December 2007//2008//***

MCSHC Medical Director, Dr. Judith Ganser, coordinates Addressing Asthma from a Public Health Perspective in conjunction with Indiana Department of Environmental Management. The Asthma Program organized the Indiana Joint Asthma Coalition and developed a state Asthma Plan. OMPP and ISDH provide an Asthma case management program for Medicaid clients./2007/The State Asthma Program is now fully staffed and beginning implementation of the state Asthma Plan. The Asthma Program resides in the Chronic Disease Division of ISDH.//2007//

The MCSHC Adolescent Health Program works to improve Indiana adolescent health status regarding six major health risks (see YRBS below) and to increase Indiana adolescent access to primary health care services. The State Adolescent Health Coordinator manages the Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT) program that includes sexual abstinence education and adolescent pregnancy prevention programming as well as providing programmatic consultation to five Title V funded school-based adolescent health centers. MCSHC works in collaboration with other public and private entities (including the American Legacy Foundation Statewide Youth Movement Against Tobacco Use) to design, develop, and implement statewide initiatives to improve adolescent health, and coordinates the collection of the Indiana Youth Risk Behavior Survey.

Indiana RESPECT uses State Adolescent Pregnancy Prevention funds and Federal Sexual Abstinence Education Block Grant funds to fund three components: (1) community grant program, (2) community grant program evaluation, and (3) a statewide media campaign. Specific grant applications solicit proposals for the distinct State and Federal funding programs. Grantees provide these programs in a variety of youth-serving organizations including schools, faith based organizations, and community organizations. Montgomery, Zukerman, and Davis, an Indianapolis advertising agency, will implement and measure the effectiveness of Indiana's statewide sexual abstinence and adolescent pregnancy prevention media campaign. Free broadcast-quality copies of the media materials are provided to local communities for local campaign initiatives and local media scheduling. Awareness and recall of the media campaign will be assessed by telephone surveys completed with Indiana teens and parents after each broadcast flight of the TV and radio spots.***/2008/Federal funding through the Abstinence Education Block Grant (AEBG) was discontinued on June 30, 2007.//2008//***

MCSHC Youth Risk Behavior Surveillance System (YRBS) is part of a national survey effort by CDC to monitor student health risks and behaviors in six categories identified as most likely to result in negative outcomes. YRBS was designed to determine the prevalence of health risk behaviors among youth; to assess whether health risk behaviors increase, decrease, or stay the same over time; and to examine the co-occurrence of health risk behaviors. The categories in the survey include: Tobacco Use, Alcohol and Other Drug Use, Unintentional Injuries and Violence, Adolescent Sexual Behavior, Weight and Nutrition, and Adolescent Physical Activity. The survey provides comparable state, and national data, as well as comparable data among subpopulations of youth. Health officials can use the data to monitor progress towards achieving the U.S. Department of Health and Human Services' Healthy People 2010 objectives, as well as to guide health programs. The sample collected for 2003 and 2005 was large enough for a weighted analysis of the data.

3. CSHCN

Within MCSHC, the Children's Special Health Care Services (CSHCS) program provides financial support for primary, preventive and specialty care, including physician and hospitalization for services due to the eligible diagnosis for CSHCN statewide. The Authorization Unit completes prior authorization for services from providers. Program staff assists clients with programmatic questions and facilitates the program's services and using the Indiana Family Helpline (IFHL) for referrals to other services. CSHCS and IFHL provide access to hearing impaired and non-English speaking clients through a TTY number and translation services available within IFHL. CSHCS provides regular training to County Offices of Family and Children (OFC) staff throughout Indiana regarding the use of CSHCS services and the Enrollment Form -- a common intake for CSHCS, First Steps and Medicaid used by OFC and First Steps. This training emphasizes identification of and outreach to eligible children. The CSHCS Program reimburses Family and Social Services Administration (FSSA) for local OFC staff to take CSHCS applications, gather verifications, and send applications to ISDH for eligibility determination./2007/CSHCS is beginning to implement in 2006, efforts to integrate service systems for CYSHCN. A new staff position will be created and a strategic plan developed.//2007//

/2008/The county OFC offices have been redesinated as county Division of Family Resources (DFR) offices. CSHCS reimburses FSSA for services involved in First Steps taking CSHCS applications, not for applications processed through DFR offices. //2008//

The Hemophilia Program pays premiums for a state insurance program, the Indiana Comprehensive Health Insurance Association (ICHIA), for children and adults diagnosed with hemophilia or von Willebrand disease who meet the program criteria. As applicable, premiums are paid by CSHCS or Chronic Disease.

a. Rehabilitation

CSHCS coordinates with the Supplemental Security Income (SSI) program to inform SSI recipients and applicants about CSHCS. CSHCS receives referrals from SSI to provide services

for blind and disabled individuals under age 16 and sends information about CSHCS to those SSI recipients not already enrolled. SSI enrollment data is collected by Systems Points of Entry (SPOE) data system in First Steps and by the CSHCS HIPAA compliant data collection system, Agency Claims Administration Processing System (ACAPS), which tracks participation in SSI.

b. Community-Based Care
CSHCS customer service staff are trained insurance experts, assisting families through insurance procedures to maximize coverage and eliminate gaps in service. CSHCS works to link clients to local primary care providers and specialty providers, where possible. CSHCS works through the ASK program, formally known as the Indiana Parent Information Network, to provide assistance to families of children with special health care needs as well as to professionals to disseminate information on community resources and systems of care.

4. Culturally Competent Care
MCSHC encourages all grantees (especially those in areas with large or growing minority populations) to work with local Minority Health Coalitions to develop culturally competent staff and materials. The ISDH Office of Cultural Diversity and Enrichment addresses the public health needs of minorities in Indiana by offering once a month two-day training session in cultural competency to all employees of ISDH and to local health professionals and grantee staff twice per month as well as a monthly advanced workshop. This office also distributes and analyzes a minority health disparity survey ISDH requires for all contractors. If contractors do not meet ISDH cultural competency goals, ISDH seeks alternate contractors./2007/The 2-day training sessions and an advanced workshop are held once per month.//2007//

The ISDH Office of Minority Health (OMH) works with state groups working with minority populations. These include Indiana Minority Health Coalition, IPN, and Indiana Latino Institute. ISDH OMH works with the Indiana Minority Health Coalition, Indiana University School of Medicine (IUSOM), Eli Lilly & Co., and others to increase the number of minorities drawn to health careers through scholarships, mentoring, early introduction of the health sciences, and additional preparation support.

C. Organizational Structure
Section III. State Overview

C. Organizational Structure

The Honorable Mitchell E. Daniels, Jr. (R) was sworn in Jan. 10, 2005 as Indiana's 49th Governor. Daniels replaces Joseph Kernan (D) after a hard-fought gubernatorial campaign. State Health Commissioner Gregory Wilson, M.D., resigned in January. In February 2005, Dr. Judith Monroe was appointed State Health Commissioner, the first woman to head the Indiana State Health Department. Monroe was director of the Primary Care Center and Family Medicine Residency Program at St. Vincent Hospitals in Indianapolis since 1992. She earned her medical degree from the University of Maryland and formerly worked as director of clinics with the Indiana University School of Medicine's Department of Family Medicine. Commissioner Monroe will also serve as medical director for the state's Medicaid program. This marks the first time the two agencies responsible for regulating and paying for the health care of the state's residents have had a direct connection.

The Indiana State Department of Health (ISDH) is one of several major departments in state government. ISDH has four commissions overseen by the State Health Commissioner and Deputy Health Commissioner Sue Uhl, J.D., also appointed in February 2005./2007/In 2006, ITS was split into its own commission with Jake Moelk as Assistant Commissioner.//2007//
/2008/Mary Hill R.N. Esq. was appointed Deputy Health Commissioner effective November 15, 2006.//2008//

The Operational Services Commission oversees three special institutions: Indiana's Soldier and Sailor's Children's Home, Indiana Veterans' Home, and Silvercrest Children's Developmental Center. Operational Services also provides Finance, Facilities Coordination and other administration for ISDH. The new Senior Director of Finance, Lance V. Rhodes, manages this commission under the authority of the Deputy Commissioner./2007//ISDH closed the Silvercrest Children's Developmental Center in May 2006. Residents have been transitioned to rejoin their families or communities. A collaborative group of parents, advocates and state agency representatives has been meeting to develop a comprehensive community-based system of services for children with developmental disabilities.//2007//***/2008/ This commission has taken on oversight of the WIC Program, Legal Affairs Office, Public Affairs, Utility Services, and Vital Records.//2008//***

The Information Services and Policy Commission lead by Assistant Commissioner: Joe Hunt, M.P.H., houses Information Technology Services (ITS), Epidemiology Resource Center (ERC), ISDH Laboratories, External Information Services (EIS), Public Health Preparedness, Utility Services, Vital Records, Office of Policy, and Quality Improvement/Statistics.***/2008/ He is being assisted by Dr. Ted Bailey who has had much experience in laboratory medicine,public health, and preparedness.//2008//***

The Health Care Regulatory Commission under Assistant Commissioner Terry Whitson, J.D., regulates Acute Care Facilities, Long Term Care Facilities, Consumer Protection, Medical Radiology Services, Sanitary Engineering, and Weights and Measures.

The Community & Family Health Services Commission houses MCSHC, WIC, Community Nutrition, Local Liaison Office with local health departments, Chronic/Communicable Disease, Immunization, Human Immunodeficiency Virus/Sexual Transmitted Disease (HIV/STD), Quality Improvement, Oral Health, and Primary Health Clinics. The new Assistant Commissioner is Loren Robertson, M.S., R.E.H.S., formerly Administrator of the Fort Wayne/Allen County Health Department./2007/Local Liaison Office was reorganized into Partner Relations and includes Rural Health, as well as communications with local health departments.//2007//***/2008/ The name of the commission was changed to the Human Health Services Commission and WIC was moved to the Operational Services Commission.//2008//***

MCSHC is responsible for administering and coordinating all parts of the Title V Block Grant for Indiana. The MCSHC Administrative Director position is vacant. MCSHC Medical Director, Judith A. Ganser, M.D., M.P.H., serves as interim director along with Assistant Director Edward M. Bloom./2007/Edward Bloom has been promoted to Director of MCSHC. The new Assistant Director is Robert K. Martin.//2007//

MCSHC distributes Title V Federal-State Block Grant Partnership budget primarily through grants to community agencies that provide direct, enabling, population-based, and infrastructure building services that impact the federal and state performance measures.

MCSHC Health Systems Development (HSD) includes subject matter experts who coordinate several MCSHC programs. HSD works closely with MCSHC Business Management to implement parts of these programs through grants and contracts. HSD consultants provide training and technical assistance to MCSHC grantee agencies and individually facilitate programs such as Indiana Family Helpline (IFHL), Prenatal Substance Use Prevention Program (PSUPP), Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT), and the Free Pregnancy Test Program (See Section B). HSD consultants build health services infrastructure with community organizations within their assigned counties. See attached HSD consultant county assignment schedule and map. One HSD team leader also serves as MCSHC Training Manager to facilitate training opportunities for MCSHC staff, other ISDH employees and grantee staff. One HSD consultant oversees the ICCHCP and another oversees PSUPP and IFHL.

Grant programs funded by MCSHC using Title V funds include: Indiana Women's Prison Families Project, Statewide Healthy Families Abuse Prevention, Statewide Family Planning Monitoring and Data Collection, Statewide Perinatal Health Care Planning, Statewide Suicide Prevention, 13 Prenatal Medical Care Clinics, 13 Infant Health Care Clinics, 15 Child Health Care Clinics, 5 School Based Adolescent Health Clinics, 4 Women's Health Care Clinics, 4 Children and Families Dental Services Programs, 23 Prenatal Care Coordination Programs, 13 Family Care Coordination Programs, 11 Family Planning Programs, 4 Childhood Obesity Programs, 5 Genetics Clinics, 3 Prenatal Genetics Programs, 2 Lead Poisoning Prevention Programs, 7 Community Needs Assessment Projects, 3 Fetal Infant Mortality Review Projects, and a number of pilot projects designed to test new approaches to health service delivery and infrastructure building. MCSHC also uses Title V to provide partial funding for several PSUPP clinics, the Indiana Poison Control Center, some RESPECT projects, prophylactic penicillin for children with Sickle Cell disease, an outreach program for Amish families with bleeding disorders, and the production of technical manuals and training programs for MCSHC staff and grantees./2007/Because of increasing costs and reductions in Title V funding as well as reductions in other fund sources, MCSHC is reducing the amount of funds granted to local agencies.//2007///***2008/MCH now supports : Indiana Women's Prison Families Project, Statewide Healthy Families Abuse Prevention, Statewide Family Planning Monitoring and Data Collection, Statewide Perinatal Health Care Planning, Statewide Suicide Prevention, 14 Prenatal Medical Care Clinics, 12 Infant Health Care Clinics, 12 Child Health Care Clinics, 6 School Based Adolescent Health Clinics, 3 Women's Health Care Clinics, 3 Children and Families Dental Services Programs, 26 Prenatal Care Coordination Programs, 14 Family Care Coordination Programs, 11 Family Planning Programs through a contract with the Indiana Family Health council, 1 Childhood Obesity Program, 5 Genetics Clinics, and 4 Fetal Infant Mortality Review Projects. Most special projects started in FY 2005 are now no longer receiving funds from MCH, although several of them remain active with local funds. All Title V Family Planning services are now provided through a statewide grant //2008//***

Some programs including the Newborn Screening Program, Meconium Screening for Drug-Exposed Newborns Program, Newborn Hearing Screening Program, IFHL, Free Pregnancy Test and some population-based educational campaigns, including the Folic Acid Awareness Campaign, are directly administered by MCSHC. HSD and Newborn Screening are under the direction of Nancy Meade, R.D., M.P.H., MCSHC Health Planner/Programs Manager, who also co-chairs the needs assessment process.

MCSHC Data Analysis section provides data entry, technical support, and data analysis. The Data Analysis team gathers the majority of the data for the Title V annual report as well as the needs assessment process. The team also contributes to the Data Integration Steering Committee that is responsible for overall data integration and data sharing efforts agency-wide. The data gathering effort involves collecting data from programs and agencies ranging from Indiana State Police (demographic data regarding truancy and arrests of minors) to the Department of Education (school attendance and enrollment information) to all MCSHC projects and clinics (clients served in various programs) and more in order to provide detailed data required for the Title V Block Grant. The Data Analysis Section also maintains the MCSHC portion of the ISDH web page.

MCSHC Business Management staff manages all contracts and grants, prepares Grant Application Procedures (GAP), facilitates review of grant and contract applications, and monitors grant and contract expenditures. This section makes Title V budget planning recommendations and coordinates all applications for funding, including primary responsibility for preparing the Title V grant application and annual report narrative. MCSHC Business Management staff coordinates all contracting, procurement and programmatic financial tracking, as well as providing a clerical support pool for the division. ***/2008/The Business Management section has been reorganized.***

Clerical support and financial tracking functions are now directly under the Asst Director. The Grant Coordinator now supervises only the Asst Grants Coordinator. The Grants Coordinator position is currently vacant.//2008//

The MCSHC management team consists of the Administrative Director (vacant), Medical Director (a pediatrician with a Masters of Public Health), Assistant Director, MCH Health Planner/Programs Director, Cultural Diversity & Enrichment Director, CSHCS Claims Director and CSHCS Eligibility Director. See attached organizational chart./2007/The Assistant Director has now been promoted to MCSHC Administrative Director. The new Assistant Director is Robert K. Martin, Colonel, U.S. Army, Retired. The Assistant Director directly manages the Data Analysis and Business Management sections and also supervises a Health Planner. The Assistant Director also works with CSHCS to develop the Integrated Services initiative.//2007//

The Assistant Director (BS Health & Physical Education, CGSC military science graduate) w/business & automation skills coordinates personnel/facility issues & supervises the Data Analysis & Business Management team leaders.

The Data Analysis Section headed by a Public Health Administrator with a BS in Education and 20 years data analysis experience, provides data entry & analysis for MCSHC. This section includes 2 data analysis clerks & a technical consultant/web designer, as well as a data mgmt Coordinator.

The Business Management Section, under a Grants Coordinator with a BS (general education) and 12 years grant management experience, coordinates contracting, financial tracking, grant application and provides a clerical pool. This section includes a Program Coordinator & Admin. Asst, w/more than 15 years exp. w/State government and three clerical/data entry staff. ***/2008/The Grants Coordinator position is currently vacant. The Program Coordinator position duties have been revised to serve as Assistant Grants Coordinator. The Administrative assistant position is also currently vacant. On an interim basis, clerical and administrative support staff, as well as the Assistant Grants Coordinator report directly to the Assistant Director.//2008//***

The MCH Health Planner/Programs Director, an RD and MPH w/more the 30 years experience in maternal and child health, supervises the MCH Health Systems Development and Genomics in Public Health / Newborn Screening section team leaders.

Three HSD Teams Leaders (one with a PhD & MSW, 1 with BS in English & Psychology & 1 w/BS Public Admin) coordinate the HSD team of 3 Chief Nurse Consultants (1 RN, MSN for prenatal health, 1 RN, MS for early childhood & 1 vacant position), a MSW/LCSW HSD Consultant, the State Adolescent Health Coordinator (MPH) and the Indiana Family Helpline Program Coordinator (BA, MS, CIRS) who leads a team of 5 state and 6 contract data and clerical staff./2007/The State Adolescent Health Coordinator accepted a promotion outside of the division, and has been replaced by another MPH.//2007//

The Genomics/Newborn Screening Director (MS, CGC) supervises two RN Chief Nurse Consultants, a Public Health Administrator, Social Services Specialist, Secretary and 2 clerical staff as well as a contracted State Audiologist. In addition she oversees, a Public Health Administrator who coordinates IBDPR &and the vacant State Genetics Specialist position and 2 contracted Genomics Program Consultants - 1 RD & 1 Genetics Counselor (MS, ABGC eligible). MCSHC is in process of transitioning these 2 contractors into state positions./2007/The State Genetics Specialist position was filled by a MS, ABGC eligible. This person has been promoted to Genomics & Newborn Screening Director, leaving the Genetics Specialist position vacant again. The IBDPR is a separate program under the Genomics & Newborn Screening Program.//2007//

The CSHCS management team includes the Eligibility Manager (RN), a Claims Manager (MA), and one RN/MSN who coordinates Prior Authorization and the cultural diversity and enrichment

program, and a RN who manages the Provider Relations Section. ***/2008/CSHCS was reorganized to incorporate an Integrated Services Program and a separate Provider Relations Sections to implement new Indiana requirements for CSHCS providers to register to allow payment via electronic funds transfer.The revised organization of CSHCS is: MCSHC Dir. (also serving as CSHCS Dir.), MCSHC Med. Dir. (also serving as CSHCS Med. Dir.) CSHCS Program Dir. supervising the CSHCS Claims Mgr & CSHCS Systems Mgr., Integrated Services Dir., an Eligibility section, & a Prior Auth. section. //2008//***

D. Other MCH Capacity

CSHCN Eligibility has 2 RN Public Health Nurse Consultants, 2 RN Welfare Nurse Consultants, 2 Welfare Consultants, 8 secretaries and 2 clerical staff. Prior Authorization has 3 RN Public Health Nurse Consultants, 2 Welfare Consultants, a Social Services Specialist, Environmental Scientist and an Administrative Assistant. Claims has a Program Director (vacant), a Health Planner, 2 Social Services Consultants, 2 Program Coordinators, 2 account clerks, a Social Services Specialist, 5 clerical staff and 2 secretaries./2007/CSHCS Eligibility has 1 Program Director, 2 RN Public Health Nurse Consultants, 2 RN Welfare Nurse Consultants, 2 Welfare Consultants, 8 secretaries and 4 clerical staff. Prior Authorization has 1 Program Director, 2 RN Public Health Nurse Consultants, 6 Nurse Consultants, and an Administrative Assistant. Claims has 1 Program Manager, 1 Program Director, a Health Planner, 7 account clerks, and 1 secretary. Provider relations has 1 Program Director, 1 Social Services Specialist (vacant), 1 Program Coordinator, 1 Account Clerk and 1 Secretary (vacant).//2007//
/2008/CSHCS re-aligned positions internally. Eligibility now has 1 RN Public Health Nurse Consultant, 2 RN Welfare Nurse Consultants, 1 Welfare Consultant, 8 eligibility clerks, and 4 clerical assistants. The Director of Claims also serves as director of Systems with 1 health planner and 1 program coordinator, and Director of Administration section with 1 administrative assistant. There are 6 clerical assistants.//2008//

MCSHC staff includes approximately seven parents or grandparents of children with special health care needs. Two are in NBS and four are part of the IFHL, including the IFHL coordinator. MCSHC, through a contract with the Indiana Perinatal Network, Inc., supports a SIDS parent who runs the SIDS program in Indiana. A contract with Indiana Parent Information Network also supports parent involvement.***/2008/ Indiana Parent Information Network has changed their name to About Special Kids (ASK)//2008//***

MCSHC also supports one dentist, a dental hygienist, four fluoridation staff and two secretaries in the Oral Health Program; one lawyer in ISDH legal department; two Information Technology Services staff plus three contractual positions in ITS; and one Epidemiology Resource Center professional./2007/In FY 2007, MCSHC supports the following staff outside of the division: two clerical and five professional Oral Health Services staff, three Information Technology staff and four IT contractors, an epidemiologist (vacant) and two contracted epidemiologists, the director of Community Nutrition and Obesity Prevention (a MPH), two laboratory staff (a microbiologist and a chemist) one clerical staff and four professional/administrative staff for the Lead Poisoning Prevention Program as well as the Lead Poisoning Prevention Director.//2007//
/2008/The Director of Oral Health position, which is currently vacant, now reports to the MCSHC Director. See section D. //2008//

E. State Agency Coordination

Public Health Relationships
The public health system in Indiana includes ISDH and 94 autonomous local health departments (LHD) that are functions of county or municipal government. MCSHC coordinates with the ISDH LHD liaison office and local health departments to facilitate development of health systems in counties of need. MCSHC provides Title V funding to Marion, Lake, St. Joseph, and Madison

counties for FIMR projects. Title V funding to other LHD MCH programs promotes direct services clinics, enabling case management services, infrastructure building services and population based services through free pregnancy testing programs and media campaigns.

ISDH MCSHC works with other parts of ISDH through informal and formal staff assignments, collaborative initiatives, technical assistance, development of policy, state plans and funding of programs. These include coordination with the Lead Prevention Program to develop policy and programs and Title V funding of a prenatal lead testing program, sitting on the State Immunization Program Committee, funding of the statewide Dental Sealant Program, and population based surveys through the Oral Health Department and the IU School of Dentistry, sharing of educational materials, and providing technical assistance to the Division of HIV/STD, Office of Cultural Diversity and Enrichment to provide mandatory cultural competence trainings for all Title V funded projects, Newborn Screening, co-location of clinics and shared funding with the Office of Primary Care and work to integrate MCSHC programs with FQHC & CHC programs, and WIC and Community Nutrition programs to develop a state breast feeding plan, chronic disease asthma program, and a state obesity prevention program. All of these ISDH divisions are housed alongside MCSHC within ISDH Community & Family Health Services Commission./2007/MCSHC provides funds to support several initiatives under the Community Nutrition and Obesity Prevention division.//2007// ***/2008/Oral Health Director position is currently vacant and the MCSHCS Medical Director is acting State Oral Health Director. A state breastfeeding plan was developed.//2008//***

MCSHC also works with ISDH departments outside of the Community and Family Health Services Commission including collaboration with Epidemiology staff to develop the Operational Data Store (ODS) to create a common health status database to collect health status and services information across several program areas and provide for more comprehensive data analysis, Vital Records, the Office of Minority Health to address disparity issues, and the Office of Women's Health education and planning.***/2008/Commission name is Human Health Services.//2008//***

MCSHC has an ongoing relationship with the Bioterrorism Preparedness Program within ISDH. MCSHC collaborated with the ten public health preparedness district epidemiologists to collect assessment data on each county and Systems Development consultants were reassigned counties to correspond with the ten public health preparedness districts./2007/The FY 2007-2008 MCH Grant Application Procedure requires applicants to coordinate activities with local and/or regional health emergency preparedness coordinators.//2007//***/2008/The MCSHC Medical Director has discussed the issue of preparedness for pregnant women, infants and CSHCN with the ISDH Preparedness Program. They will be setting up plans for vulnerable populations this year. The MCSHC Medical Director will also be working with Indiana Chapter of the March of Dimes to raise awareness about preparedness for pregnant women around the state in Fall 2007. //2008//***

MCSHC provides partial funding for the Indiana Poison Control Center (IPC), operated by Clarian Health Partners. IPC provides statistical data to MCSHC and also by contract provides epidemiological surveillance for potential bioterrorism or chemical disaster clusters by region, nature and frequency of incident reports.***/2008/State Department of Health is paying for the Indiana Poison Control Center with tobacco funds for 2008.//2008//***

Relationships with Social Services
The Indiana Family and Social Services Administration houses the Division of Family Resources which encompasses Temporary Assistance to Needy Families (TANF), food stamps, child care, foster care, adoption, homeless services, and job programs; the Division of Disability and Rehabilitative Services which encompasses in-home services, deaf and hard-of-hearing services, blind and visually impaired services, and social security disability eligibility; the Division of Mental Health and Addiction, and the Office of Medicaid Policy and Planning.

ISDH and FSSA share data through a Memorandum of Understanding (MOU) that addresses general areas of collaboration and data interchange as well as specific issues like reimbursement for lead lab tests and IFHL outreach for FSSA services for children with special health care needs who are eligible for both Hoosier Healthwise and CSHCS. This includes eligibility for SSI through the FSSA Disability Determination Bureau and services through the FSSA Vocational Rehabilitation Services.

MCSHC coordinates with Indiana Family and Social Services Agency (FSSA) to expand Hoosier Healthwise (Medicaid) coverage, develop comprehensive early child care systems including the Early Childhood Comprehensive Systems Program (ECCS) and the Indiana Child Care Health Consultant Program (ICCHCP), provide partial funding for the Healthy Families program and receive funding for the PSUPP./2007/The ECCS program was renamed "Sunny Start: Healthy Bodies, Healthy Minds".//2007///***2008/The Sunny Start project manager serves on the Head Start Collaboration Office Advisory Council. //2008//***

The MCSHC Medical Director serves on the First Steps Interagency Coordinating Council and the Board for the Coordination of Child Care with FSSA staff and other state agencies and consumers./2007/The Board for Coordination of Child Care has been replaced by an advisory board made up primarily of child care providers.//2007//

ISDH and FSSA coordinate with WIC, CSHCS and First Steps to reduce duplication and ensure coverage for all eligible infants and children. CSHCS and FSSA provide joint planning, outreach and training for county systems points of entry to determine Medicaid and/or CSHCS eligibility. MCSHC standards of care for prenatal care coordination and child health programs require developmental screening and referral to First Steps for children age 0-3.

MCSHC staff serves on FSSA's Indiana Head Start Partnership Project Advisory Council. Federal funding from DHHS, Administration for Children and Families has enabled Head Start programs to provide comprehensive services for low-income Hoosier children and their families for over 35 years./2007/The Indiana Head Start Partnership has been renamed the Indiana Head Start Collaboration Office.//2007//

MCSHC requires all grantees to provide EPSDT and accept funding from Medicaid as payment in full. Medicaid provides reimbursement for EPSDT.

MCSHC houses the Prenatal Substance Use Prevention Program (PSUPP) with partial funding from Title V, FSSA Division of Mental Health and Addiction, and Indiana Tobacco Prevention and Cessation (ITPC). PSUPP works to prevent poor birth outcomes by helping women to decrease or cease alcohol, tobacco and other drug use during pregnancy. PSUPP is implemented statewide through the efforts of a MCSHC state program director, twenty local directors and an evaluation team. The local directors collectively serve, but are not limited to, constituents from twenty-two Indiana counties that include: Allen, Clark, Dearborn, Dubois, Delaware, Elkhart, Franklin, Jennings, Lake, LaPorte, Madison, Marion, Ohio, Owen, Putnam, Ripley, Spencer, Switzerland, Tippecanoe, Vanderburgh, Vigo, and Warrick./2007/Pike, Grant, and St. Joseph counties have been added for a total of 25.//2007///***2008/House Enrollment Act 1457, effective July 1, 2007, establishes the Prenatal Substance Abuse Commission to develop a plan to improve early intervention and treatment for pregnant women who abuse alcohol, tabacco, or drugs. This commission is to convene before October 15, 2007.//2008//***

MCSHC supports efforts to promote education and screening for perinatal depression. The Indiana Perinatal Network received a three-year continuation grant from HRSA to develop a perinatal depression state plan, including provider training and protocols./2007/Indiana Perinatal Network will be facilitating the second regional perinatal depression summit and certificate of completion course in Bloomington , in August 2006. The "Decision Tree for Depression During the Childbearing Years", a tool to assist professionals in identifying, treating, and referring women for post partum depression has been added to the IPN website and can be downloaded for use

by professionals. For consumers, "Something Isn't Right: Do You Have Depression" has been added to the IPN website and includes the Edinburgh Screening Test that is taken and scored online. Women with a high score placing them at risk for suicide are referred to their ER for immediate assistance.//2007//

MCSHC provides partial funding for Healthy Families Indiana (HFI), a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education available in all 92 counties. Part of Healthy Families America, HFI provides support to families with their first newborn whose hospital or prenatal screens indicate that they are at risk for child abuse. HFI is also funded by FSSA and the Indiana Criminal Justice Institute and receives additional support through TANF funds, a specialized license plate, Kids First, and other sources.

MCSHC receives funds from FSSA to coordinate the ICCHCP that provides consultation on health and safety issues to child care providers by site visit and phone and provide health and safety information, educational materials and contact information via the internet, access to resources, reports and data on the website./2007/Pilot projects in Lake (Gary) Dubois and Lawrence counties provide a greater concentration of services for providers of child care. The pilot will also focus on involving medical and health service providers in the support for child care.//2007//***/2008/The program will transistion in September 30, 2007 when FSSA resumes responsibility for child care health consultation in conjunction with the newly developed Quality Rating Systems program to be rolled out in January 2008.//2008//***

The new State Health Commissioner also serves as Medical Director for the State Medicaid program--appointed to that position by the Governor to better coordinate ISDH and Medicaid policy. MCSHC coordinates with FSSA Office of Medicaid Policy and Planning (OMPP) to expand Hoosier Healthwise (Medicaid) coverage. Many Title V grantees became Medicaid enrollment centers for Hoosier Healthwise when the State expanded the program for SCHIP.

As of July of 2005 all Indiana Medicaid participants, except those with disabilities in the Medicaid Select program will be enrolled in mandatory Medicaid Managed Care Organizations (MCOs). OMPP has contracted with five MCOs to cover the state. MCSHC has been working with OMPP and the MCOs to ensure that targeted case management services remain available to meet the needs of pregnant women, infants and families.

Indiana Prenatal Care Coordination (PNCC) identifies pregnant women who are eligible for Title XIX and Title XXI and helps them apply for services. PNCC has been a Medicaid reimbursable service in Indiana since 1990. Services include outreach and case finding, home visit assessments per trimester, care plan monitoring, education, and referral to needed services. MCSHC funds local agencies and hospitals to provide prenatal care coordination in areas where mothers are at high risk for poor pregnancy outcomes. MCSHC provides technical assistance, training and oversight to funded and non-funded prenatal care coordination programs in Indiana. MCSHC works closely with the federally funded Healthy Start Programs outreach and case management initiatives in Indianapolis and Lake County./2007/Evaluation of 3 models of outreach and care coordination by the Indiana University School of Nursing's Institute for Action Research in Community Health (IARCH) was completed in April, 2006. 2 new models will be evaluated in FY 2007. Successful models will be replicated throughout the state including the faith based mentoring project out of South Bend that will be replicated in Indianapolis.//2007//***/2008/House Enrolled Act 1678 signed into law on 6/7/07 increases coverage of pregnant women from 150% FPL to 200% FPL and allows presumptive eligibility for pregnant women limited to ambulatory prenatal care. In 2007 Indianapolis has modified the South Bend faith based model and uses pastor's wives or "First Ladies" to provide health education to the congregation.//2008//***

MCSHC collaborates with the Indiana Chapter of the National Association of Social Workers to provide certification training to nurses and social workers applying to become prenatal care

coordinators.

With the entrance of Medicaid Managed Care in Indiana MCSHC found the PNCC program in jeopardy as MCOs wanted to provide care coordination services over the phone. MCSHC staff met with OMPP and the MCOs to assure that the Medicaid PNCC continued to be utilized and continued to receive reimbursement for services as stated in Indiana Code 405 IAC 1-7-24./2007/Ongoing meetings with all MCOs continue. MCO PNCC Operational Guidelines were finalized April 19, 2006 and will be a part of MCO contracts with prenatal care coordinators.//2007//

MCSHC staff collaborated with OMPP and the MCOs to revise the State Prenatal Risk Assessment Tool, and works to standardize assessment and report tools, revise training of prenatal care coordinators, program evaluation, and also participates in the revision of the Medicaid Code on prenatal care coordination reimbursement. At least three training events, directed to local prenatal care coordination providers, are planned in cooperation with OMPP and the MCOs to educate providers on new tools, how to contract with MCOs, billing and reimbursement under MCOs./2007/Standardization of assessment forms developed in collaboration with MCSHC, MCOs and prenatal care coordinators were completed and released in a Medicaid Bulletin in March, 2006. 3 regional trainings on use of the standardized forms were provided by MCSHC in May, 2006. 4 of the 5 MCOs attended one or more of the trainings to share their programs with Prenatal Care Coordinators and to facilitate initiation of contracts.//2007//

Relationship With Other State Agencies
MCSHC funds Indiana School for the Deaf (ISD) to support EHDI programs by providing training materials, a video project and regional audiologists to outreach to hospitals, audiologists and First Steps programs statewide to identify, promote, support and educate families with infants newly diagnosed with hearing loss in language development./2007/ISDH now contracts directly with regional audiologists, but continues to support other ISD initiatives.//2007//

MCSHC receives funds from Indiana Department of Education (IDOE) to perform the Youth Risk Behavior Study (YRBS) to identify and reduce high-risk behaviors among school age children. ISDH partners with IDOE to improve the health of Indiana children through the schools. IDOE has received a 5-year grant from the Centers for Disease Control and Prevention to bring the Coordinated School Health Program model to Indiana. The grant includes staff members in both state agencies./2007/In 2005, Indiana was able to report weighted data for the second time on the YRBS.//2007//***/2008/In 2007, ISDH collected data for the YRBS which has been sent to CDC for analysis. It is unknown at this time whether Indiana will have weighted data again.//2008//***

MCSHC provides technical assistance for school programs, policy and environmental change, educational strategies based on CDC guidelines and coordination of resources. This program has eight interactive components: Health Education, Physical Education, Health Services, Nutrition Services, Counseling, Psychological, & Social Services, Healthy School Environment, Health Promotion for Staff, and Family/Community Involvement. The key focus areas are obesity, nutrition, physical activity, chronic disease, and alcohol, tobacco, and other drugs./2007/The office for the Coordinated School Health Program is under the Deputy Health Commissioner, but MCSHC is part of the internal steering committee.//2007//

MCSHC has developed a coalition that includes IDOE, to implement the Early Childhood Comprehensive Systems program to create an integrated, coordinated, comprehensive system of services for children from birth to five. This initiative will help to ensure that a holistic system of care supports young children so they arrive at school ready to learn./2007/The Sunny Start: Healthy Bodies, Healthy Minds Program (formerly the ECCS) Grant was funded by the Maternal and Child Health Bureau for 2 years of planning activities that began in 2003. In June 2005, a strategic plan was developed to support a coordinated system of resources and support for young

children from birth to age 6 and their families.//2007//

MCSHC works with the Indiana Department of Corrections through coalitions, and programs that provide services to prevent child abuse such as IHF, and the ICCHCP. MCSHC funds the Indiana Women's Prison's Responsible Mothers/Healthy Babies program to build and preserve the mother/child/family bonds while women are in prison.

Relationships With Universities
Over the years MCSHC has developed a relationship with the Indiana University Schools of Medicine and Nursing, and the new Department of Public Health. MCSHC collaborates with the Indiana Perinatal Network (IPN) and with these educational institutions to develop, sponsor, and coordinate training events for health care professionals in public and private health settings.***/2008/The Marion County Health Department, ISDH MCSHC and IPN sponsored a one day conference on Prenatal Substance Abuse with speakers from Indiana University School of Medicine in Fall 2006. There will be an Unintended Pregnancy Summit sponsored by IPN and ISDH in September 2007. The Sunny Start (ECCS) Program is sponsoring a week long Institute on Infant and Toddler Mental Health in collaboration with Faculty from IUSM Department of Behavioral Pediatrics on July 9-13, 2007.//2008//***

MCSHC contracts with IU professors to evaluate pilot programs and conduct focus groups and town meetings around the issue of perinatal disparities. MCSHC has a long relationship with the IU Bowen Center to provide statistical evaluation of the PSUPP program and other funded initiatives. This year the Director of Adolescent Medicine will evaluate Indiana's RESPECT programs./2007/The evaluation is on hold due to funding constraints.//2007//

MCSHC links with state universities through the Masters of Public Health Program at Indiana University (IU) and the Center for Public Health Leadership and Education. Medical students from the IU Medical School are provided with preceptors for a public health rotation. Riley Infant and Childhood Nutrition Fellows at Clarian's Riley Hospital for Children are provided Title V background information. The MCSHC Medical Director serves on the advisory board for the MCHB funded Adolescent Health Training Program, Riley Child Development Program, and Behavioral Pediatrics Program./2007/MCSHC works closely with Purdue University in regards to the Folic Acid Program and Indiana Suicide Prevention Coalition.//2007//

MSCHC works with IU School of Dentistry (IUSD) to provide the statewide Dental Sealant Program. Title V and Children's Oral Healthcare Access Program (COHAP) funds support a mobile dental unit to provide school-based dental sealants in rural areas, particularly those near community health centers. Student dentists and hygienists staff the unit. MCSHC also provides funds to IUSD to support the craniofacial reconstructive surgery unit for children born with dental deformities including cleft palate.

Indiana Minority Health Coalition
MCSHC collaborates with the Indiana Minority Health Coalition (IMHC) to provide consultation for MCSHC grantees. MCSHC funds prenatal care coordination (case management) and support services for pregnant minority women in two of the most populous counties as part of the effort to lower minority infant mortality and disparity. Through 15 local Minority Health Coalitions, IMHC provides an immunization outreach program that works with local health departments and MCSHC projects to provide immunizations and health care. The IMHC Director also serves on the Steering Committee of Core Partners for ECCS.

MCSHC collaborates with local minority coalitions in Indianapolis, Gary, South Bend, Fort Wayne, Elkhart and Evansville to assist with development of local coalitions to address local perinatal disparity issues, conduct town meetings, work with faith based organizations to provide culturally competent services to African American families.

Helpline

MCSHC Indiana Family Helpline (IFHL) is a partner in IN211, Inc. IFHL and MCSHC staff have participated in the development of IN211 because IFHL is the only statewide I&R service. IFHL also assists the IMHC hotline by providing the database software and data./2007/IFHL no longer provides the database software for IMCH.//2007//***/2008/The IFHL will work to become an 211 call center by December 2008.//2008//***

Indiana Perinatal Network
MCSHC implements several programs through the Indiana Perinatal Network, Inc (IPN). These include the Indiana Perinatal Systems Strategic Plan for the 21st Century, developed through a series of regional town meetings and state task force groups. IPN builds infrastructure, provides professional and public education on perinatal health issues and quality assurance standards of care for perinatal services in Indiana. IPN houses the Sudden Infant Death (SIDS) program and the MCSHC Breastfeeding Program and provides a statewide Advisory Board for program planning, Regional Perinatal Advisory Boards, a speaker bureau, and a multi-media public education campaign. IPN also publishes Indiana Perinatal News (IPN newsletter), the Indiana Prenatal Online Magazine http://www.indianaperinatal.org, consumer information, clinical practice alerts, critical reports, and consensus documents like the Indiana Prenatal Guide. MCSHC also funds IPN to operate a pilot project to provide and evaluate Doula services in Marion County and the Indiana Friendly Access program to identify best practices to increase satisfaction with and utilization of health care services for low income pregnant women and children and to more clearly identify and address barriers to health care for pregnant women and families with young children.

Tertiary Care Centers
MCSHC funds a CSHCS satellite office at Riley Hospital to provide CSHCN and their families easily accessible and expedited entry to the CSHCS program. MCSHC funds the Riley Hospital Comprehensive High-Risk Newborn Follow-up Program to provide follow-up to children and their families who are at the highest risk, medically and developmentally, of morbidity or mortality and build community-based infrastructure for these fragile children./2007/Two social workers at St. Vincent's Hospital Pediatric Cancer ward take CSHCN applications and are kept up to date on changes to the application process.//2007//

IPN in collaboration with ISDH, ACOG (American College of Obstetricians and Gynecologists), the State Perinatal Advisory Board and Indiana hospitals that provide perinatal health care, developed a consensus statement on Levels of Hospital Perinatal Care in Indiana to establish criteria for risk-appropriate levels of hospital obstetric and neonatal care and provide recommendations for appropriate consultation, referral and transport. There are a total of five full Level III Obstetric Hospitals in Indiana: IU Hospital, Methodist Hospital, St. Vincent Hospital, and Wishard Hospital in Indianapolis, and Memorial Hospital in South Bend. Riley Children's Hospital and St. Vincent Hospital in Indianapolis have the only two Level III/D Neonatal Intensive Care Units in the state. However, a total of six other hospitals are considered Level III/Subspecialty B-C. These are located in Indianapolis, South Bend, Evansville, Newburgh, Muncie and Fort Wayne. IPN provides the Perinatal Continuining Educational Program (PCEP), a comprehensive program for those involved in the clinical bedside care of obstetrical and neonatal patients that teaches concepts and skills important to the care of high risk patients as well as patients stabilized prior to transfer to a sub-speciality center. The PCEP coordinator sets up training with one of the tertiary centers that then invite neighboring Level I and II hospitals to participate in the training program. The Level I and II hospitals are encouraged to create a MOU with the tertiary hospital to stabilize and transport high-risk pregnant women and neonates.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	37.1	38.7	29.6	28.9	28.2
Numerator	1591	1664	1276	1243	
Denominator	429345	430166	430557	430439	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
FY2006 data not yet available. Estimate provided based on trend analysis.

Notes - 2005
Source of data: ISDH Chronic Disease Program

Notes - 2004
Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Indiana Asthma Coalition

Narrative:
Notes - 2005
Data for 2005 not yet available. Estimate provided based on previous year baseline.

Notes - 2004
Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Notes - 2003
Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Narrative:
#01 HEALTH SYSTEMS CAPACITY INDICATOR The rate of children hospitalized for asthma (10,000 children less than five years of age)

Since 1990, the prevalence of asthma for children 18 and under has doubled in Indiana, and currently 8% of all Hoosiers have asthma, placing Indiana 14th in the nation in asthma prevalence.(L. Stemnock and J. Lewis, "Asthma Prevalence in Indiana,"Indiana State Department of Health (ISDH) Epidemiology Resource Center/Data Analysis Unit, 2001). However, the rate of Indiana children less than five years of age hospitalized with asthma has decreased from 38.7/10,000 in 2003 to 29.6/10,000 in 2004. This data was obtained from Indiana Hospital

Discharge Data through the ISDH Epidemiology Resource Center. The reason for such a major reported decrease is greatly improved data from the Health and Hospital Corporation of Marion County, whose discharge data was until 2003 based on projections that were overstated. Now that we have established a reliable means of getting accurate data, we will use 2003 as a baseline.

In October 2002, the ISDH and the Indiana Department of Environmental Management (IDEM) were awarded interagency funding by the Centers of Disease Control and Prevention's (CDC) National Asthma Program for capacity building and asthma plan implementation.

In December 2004 the Indiana Joint Asthma Coalition, ISDH and IDEM published A Strategic Plan for Addressing Asthma in Indiana, a five-year strategy to begin addressing the burden of asthma in Indiana that includes a data surveillance plan. Currently, Indiana asthma surveillance involves the collection of prevalence, severity, and cost data using the Behavioral Risk Factor Surveillance Survey (BRFSS), Medicaid claims data, hospital discharge data, and mortality statistics. Each of these data sets has inherent limitations. For example, the BRFSS gives us data on adults only, patterns of health care are limited to Medicaid recipients, and hospital discharge data prior to 2002 was not individually identifiable which prevents trend analysis of hospitalizations.

The Data and Surveillance Workgroup of the Indiana Joint Asthma Coalition will work toward identifying gaps in present data sources describing the asthma burden and accessing additional data sources. Strategies of the workgroup include: 1) Solicit, inventory, and review the data needs, 2) Identify key users of asthma data in Indiana and review their data needs, 3) Identify gaps in present data collection and identify potential data sources to fill these gaps, and 4) Establish standardized data definitions, data analysis methods, and surveillance standards, utilizing nationally recognized definitions as applicable. In addition the workgroup will include geostatistical (GIS) analysis, the linkage of asthma prevalence with environmental data, and schools response in preventing and responding to asthma among students.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	70.2	72.1	65.6	61.4	61.4
Numerator	55686	58251	53875	52964	
Denominator	79325	80791	82169	86298	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
FY2006 EPSDT data not verified. Estimate provided based on baseline.

Notes - 2005
Data provided By OMPP using their new data system. This should be treated as base year data.

Narrative:
Notes - 2005
Data provided By OMPP using their new data system. This should be treated as base year data.

Notes - 2003
Source of Numerator & Denominator: Office of Medicaid Policy & Planning.

Narrative:
The percent of Medicaid enrollees whose age is less than one year during the reporting year who received one initial periodic screen.

The percent of Medicaid enrollees whose age is less than one year during the reporting year that received one initial periodic screen was reported by Medicaid as 65.6% for 2004. Medicaid's modifications to their computer system eliminated some unintentional duplication present in 2003's figures. Indiana mandatory Managed Care for the MCH Medicaid population began phase-in transition in 2002. Managed Care prenatal care providers have been encouraged to assist the mother with enrollment of the baby with a managed care provider prior to delivery.

In July 2005, five Medicaid Managed Care Organizations (MCOs) will cover all 92 counties in Indiana and will provide services for all Medicaid participants except those in Medicaid Select. The Indiana Prenatal Care Coordination program, and Healthy Families work closely with the MCOs and also assist in getting the infant into primary care. Performance data specific to each of the Hoosier Healthwise risk-based managed care plans will be published yearly by the Office of Medicaid Policy and Planning (OMPP).

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	37.5	59.0	14.2	12.1	40.4
Numerator	605	1662	225	186	
Denominator	1613	2817	1581	1531	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2006
FY2006 data not yet available. Estimate provided based on baseline figure.

Notes - 2005
OMPP's new computer system had some necessary corrections which have now been made. 2003/2004 data will be changed by OMPP.

SFY 2005 data shoudl be considered as base line and is the most accurate data available.

Notes - 2004

OMPP's new computer system is giving ISDH more accurate data than in prior years. 2004 figures should be used as baseline figures.

Source of data: Indiana Medicaid

Narrative:
Notes - 2005
OMPP's new computer system had some necessary correctionswhich have now been made. 2003/2004 data will be changed by OMPP.

SFY 2005 data shoudl be considered as base line and is the most accurate data available.

Notes - 2004
OMPP's new computer system is giving ISDH more accurate data than in prior years. 2004 figures should be used as baseline figures.

Source of data: Indiana Medicaid

Notes - 2003
Source of Numerator & Denominator: Office of Medicaid Policy & Planning. Figures for 2003 are being checked for accuracy by OMPP. Figure reported was incorrect due to computer error at OMPP. Actual figures for 2003 to be supplied by Medicaid before end of FY04.

Narrative:
The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

In Indiana, there were 618 SCHIP enrollees whose age was less than one year at the end of the fiscal year. There were a total of 1,531 unduplicated SCHIP enrollees during the fiscal year who had at least one initial or periodic screen. From this data, it is not possible to determine the total number of unduplicated SCHIP infants <1 year of age who had at least one periodic screen, as the figure available contains duplicates.

Additionally, this information was only provided by Medicaid in estimate form prior to the installation of Medicaid's new computer system. Medicaid reported making corrections to their new computer system. Thus, 2005 data rather than 2004 data will be used as baseline data.

This measure has been subject to high variability in the past due to small numbers. SCHIP and Medicaid enrollment appears to have an inverse relationship. All of our funded MCH Projects are encouraged to become Medicaid/SCHIP enrollment centers to facilitate easy enrollment for eligible family members.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	73.5	72.9	72.3	71.1	70.3
Numerator	62221	62972	62991	61767	
Denominator	84654	86382	87124	86887	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
Source of data: ISDH ERC. FY2006 data not yet available. Estimate provided based on trend analysis.

Notes - 2005
Source of data: ISDH ERC. Numerator calculated from percentage.

Narrative:
Notes - 2005
Data for 2005 not available. Estimate provided based on trend analysis.

Notes - 2003
Numerator is calculated from the denominator and the percentage.

Source of data: ISDH ERC

Narrative:
The percent of women (15-44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Early and continuous prenatal care is promoted through the Indiana Perinatal Network "Baby First Right From the Start" Media Campaign, which promotes early prenatal care through billboards, free consumer videos, and print materials, the State Prenatal Care Coordination program which promotes early and continuous prenatal care utilization through outreach, education, and case management, and the MCH Free Pregnancy Test Programs which provides free tests to county agencies throughout the state.

In return for free pregnancy tests, agencies agree to assist all women with a positive pregnancy test into early prenatal care. There has been an increase in the use of community health workers and Baby First advocates providing outreach to pregnant women in targeted high-risk areas of the state with special project funding during FY 2005.

In 2004, 72.3% of all women in Indiana had adequate or adequate plus prenatal visits according to the Kotelchuck Index. The rate and the denominator for this figure are provided annually by the ISDH Epidemiology Resource Center; the numerator is then calculated. The OMPP has made the percent of women entering prenatal care in the first trimester a State Medicaid performance measure for State Medicaid MCOs.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**

Annual Indicator	82.3	86.0	85.0	89.7	89.7
Numerator	404455	422501	417252	442210	
Denominator	491440	491218	490996	492835	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2006
Projection based on previous OMPP data.

Notes - 2005
Source of numerator OMPP
Denominator is calculated via trend analysis of previous OMPP data.

Notes - 2004
In FY2003 the Indiana Office of Medicaid Policy and Planning improved their data reporting capabilities via a new computer system, increasing accuracy of their data and estimates. Percentage provided for 2003 during transitional period. Numerator available for 2004. Denominator for FY2004 provided by Medicaid as an estimate of number who meet eligibility requirements as of end of FY2004.

Source of data: IOMPP

Narrative:
Notes - 2005
Source of numerator OMPP
Denominator is calculated via trend analysis of previous OMPP data.

Notes - 2004
In FY2003 the Indiana Office of Medicaid Policy and Planning improved their data reporting capabilities via a new computer system, increasing accuracy of their data and estimates. Percentage provided for 2003 during transitional period. Numerator available for 2004. Denominator for FY2004 provided by Medicaid as an estimate of number who meet eligibility requirements as of end of FY2004.

Source of data: IOMPP

Notes - 2003
In FY2003 the Indiana Office of Medicaid Policy and Planning improved their data reporting capabilities via a new computer system, increasing accuracy of their data and estimates. Percentage provided for 2003 during transition period between computer systems.

Source of data: IOMPP

Narrative:
Percent of potentially Medicaid-eligible children who have received a service paid for by the Medicaid program.

This percentage increased from 85% to 89.7% based on information from Medicaid's new

computer program.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	46.6	46.1	47.1	47.7	55.1
Numerator	65709	66880	70321	73219	68753
Denominator	141006	145088	149170	153452	124716
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006
Source of Data: OMPP

Notes - 2005
Indiana Medicaid has made some corrections to its new computer system which is providing more accurate data than in the past. 2005 rather than 2004 data should be used as baseline.

Notes - 2004
Indiana Medicaid has installed a new computer system which is providing more accurate data than in the past. However, Medicaid is still making some system corrections. 2005 should be used as baseline data.

Source of data: OMPP

Narrative:
Notes - 2005
Indiana Medicaid has made some corrections to its new computer system which is providing more accurate data than in the past. 2005 rather than 2004 data should be used as baseline.

Notes - 2004
Indiana Medicaid has installed a new computer system which is providing more accurate data than in the past. However, Medicaid is still making some system corrections. 2005 should be used as baseline data.

Source of data: OMPP

Notes - 2003
Source of Numerator & Denominator: Office of Medicaid Policy & Planning.

Narrative:
The State slashed Medicaid dental reimbursements in 1994, which led to a mass exodus of dentists from the Medicaid program, and a decrease in dental health services to Medicaid eligible children. Reforms in Indiana's Medicaid Dental Program in 2001 led to an increase in the number

of dentists providing dental health services to Medicaid enrollees.

Dental initiatives undertaken to promote utilization of dental services include Hoosier Healthwise educational brochures, referrals and advocacy from the MCSHC Indiana Family Helpline, MCSHC funding of the SEAL Mobile Unit to travel throughout the state and provide sealants to third grade students in school, requiring funded child health projects to report on the number of enrolled children receiving dental sealants, MCSHC funding of two dental health clinics within local health departments, and requirement of state funded community health centers to provide dental health.

Medicaid's new computer system has undergone some revisions in 2005; 2004's figure has been corrected following information received from those revisions. At 47.1% it still represents an increase over 2003's 46.1% and is now a reasonable and correct reported rate. The rate continued to increase in 2005 to 47.7%.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	15.5	16.4	8.4	2.0	2
Numerator	2277	2409	1662	401	
Denominator	14690	14690	19823	19823	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2006
Source of data: ISDH CSHCS. FY2006 data not yet available. Estimate provided based on baseline data.

Notes - 2005
We are able to use real data for this measure as of 2005. Previous estimated data was overinflated due to lack of updates from SSA for the denominator and projections for the numerator based on anticipated trends.

As of 2005, SSA provides an estimate on its web page of the number of SSDI recipients by state; however, there is no age breakdown for under 16. The under 18 age figure is therefore used. This means that the percentage is understated, as the denominator is somewhat inflated. Efforts are underway to deterimine a means to break out the appropriate age-range to ensure a direct comparison.

The CSHCS program provided the numerator for 2005, representing a 75% drop in number of children receiving rehabilitative services. This has been attributed by CSHCS to previous years' significant backlog of cases processed being virtually eliminated over the past two years after having been maintained at an overinflated level in years past. However, the extrememly low number may be an abberation and thus is only preliminarily a baseline.

Source of data: SSI, CSHCS program.

Notes - 2004
We are able to use real data for this measure as of 2005. Previous estimated data was overinflated due to lack of updates from SSA for the denominator and projections for the numerator based on anticipated trends.

FY 2004 will thus be used as baseline data.

As of 2005, SSA provides an estimate on its web page of the number of SSDI recipients by state; however, there is no age breakdown for under 16. The under 18 age figure is therefore used. This means that the percentage is understated, as the denominator is somewhat inflated.

Numerator is defined as CSHCS clients in FY 2004 whose service was Therapy or outpatient and who had a revenue code of 420 through 449 on a claim and whose age was less than 16 years.

To give an accurate comparative figure, the same numerator but for children age less than 18 years is 1787, so the percentage comparing under 18's in both the numerator and denominator would be 9%.

Source of data: SSI, CSHCS program.

Narrative:
Notes - 2005
We are able to use real data for this measure as of 2005. Previous estimated data was overinflated due to lack of updates from SSA for the denominator and projections for the numerator based on anticipated trends.

As of 2005, SSA provides an estimate on its web page of the number of SSDI recipients by state; however, there is no age breakdown for under 16. The under 18 age figure is therefore used. This means that the percentage is understated, as the denominator is somewhat inflated. Efforts are underway to deterimine a means to break out the appropriate age-range to ensure a direct comparison.

The CSHCS program provided the numerator for 2005, representing a 75% drop in number of children receiving rehabilitative services. This has been attributed by CSHCS to previous years' significant backlog of cases processed being virtually eliminated over the past two years after having been maintained at an overinflated level in years past. However, the extrememly low number may be an abberation and thus is only preliminarily a baseline.

Source of data: SSI, CSHCS program.

Notes - 2004
We are able to use real data for this measure as of 2005. Previous estimated data was overinflated due to lack of updates from SSA for the denominator and projections for the numerator based on anticipated trends.

FY 2004 will thus be used as baseline data.

As of 2005, SSA provides an estimate on its web page of the number of SSDI recipients by state; however, there is no age breakdown for under 16. The under 18 age figure is therefore used. This means that the percentage is understated, as the denominator is somewhat inflated.

Numerator is defined as CSHCS clients in FY 2004 whose service was Therapy or outpatient and

who had a revenue code of 420 through 449 on a claim and whose age was less than 16 years.

To give an accurate comparative figure, the same numerator but for children age less than 18 years is 1787, so the percentage comparing under 18's in both the numerator and denominator would be 9%.

Source of data: SSI, CSHCS program.

Notes - 2003
Source of denominator: Estimate provided by Social Security Administration.

Source of numerator: Provisional data, CSHCN Program.

Due to changes in both SSA's and CSHCN's databases, the figures as provided will be maintained for another year to better ensure accuracy.

Provisional FY2003 indicator is a projection based on multi-year data.

Narrative:
Indiana CSHCN Program provides rehabilitation services to children under the age of 16 receiving benefits under the Special Supplemental Insurance (SSI) Program to the extent medical assistance for such services are not provided through Medicaid. The CSHCS office provides Care Coordination, Eligibility, Prior Authorization (PA), Claims Processing, Provider Relations, and Travel Reimbursement support services for providers and participants or their families.

Until 2005, a significant backlog in case processing inflated the numerator reported by the CSHCS program, and also thus artificially inflated the percentage. This backlog has been virtually eliminated, bringing the number of children and the percentage much lower. At the same time, SSA has begun providing some data through their web site, although it has not been updated for 2005.

Therefore, while 2004 shows a marked reduction in percentage over 2003, that figure is being observed as to potentially being baseline. CSHCS is continuing to check into the computer report for the numerator, which represents a 75% reduction over 2004, but this is the best figure they can provide at this time. It is provisional and is expected to change, and is expected to bring the percentage in line with 2004's baseline data. Per SSA, their web site data should be updated for 2005 as well, hopefully by the end of the year.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	other	9.6	8.1	8.3

Notes - 2008
Projection used; FY2006 data not yet available.

Narrative:
Notes - 2007
For HSCI 05 a breakdown between Medicaid and Non-Medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:
Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	other	8.8	6.5	7.4

Notes - 2008
Projection used; FY2006 data not yet available.

Narrative:
Notes - 2007
For HSCI 05 a breakdown between medicaid and non-medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January, 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	other	72.5	85.5	78.2

Notes - 2008
Projection used; FY2006 data not yet available.

Narrative:
Notes - 2007
For HSCI 05 a breakdown between medicaid and non-medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January, 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated

as baseline data.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	other	69.7	82.5	71.3

Notes - 2008
Projection used; FY2006 data not yet available.

Narrative:
Notes - 2007
For HSCI 05 a breakdown between Medicaid and Non-Medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:
Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL Medicaid**
Infants (0 to 1)	2006	150
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2006	200

Narrative:
Narrative:
The percent of poverty level for eligibility in the State's Medicaid and State Children's Health Insurance Program (SCHIP) programs for infants (0-1), children, and pregnant women.

The OMPP under the Indiana Family and Social Services Administration administers Medicaid in Indiana. Indiana's Medicaid program covers pregnant women and children ages one and under, with family incomes up to 150 percent of poverty. Infants of mothers on Medicaid during the pregnancy are automatically eligible for Medicaid at time of birth.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program.

Indiana's SCHIP is comprised of: Phase I SCHIP - Uninsured children below the age of nineteen with family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients. Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 21) (Age range to) (Age range to)	2006	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2006	200

Narrative:
Narrative:
The percent of poverty level for eligibility in the State's Medicaid and State Children's Health Insurance Program (SCHIP) programs for infants (0-1), children, and pregnant women.

The OMPP under the Indiana Family and Social Services Administration administers Medicaid in Indiana.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program. Indiana's SCHIP is comprised of: Phase I SCHIP - Uninsured children below the age of nineteen with family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients. Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2006	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2006	200

Narrative:
Notes - 2007
Pregnant women younger than 19 years of age are covered through SCHIP up to 200% of poverty level.

Narrative:
The percent of poverty level for eligibility in the State's Medicaid and State Children's Health Insurance Program (SCHIP) programs for infants (0-1), children, and pregnant women.

The OMPP under the Indiana Family and Social Services Administration administers Medicaid in Indiana. Indiana's Medicaid program covers pregnant women and children ages one and under, with family incomes up to 150 percent of poverty. Infants of mothers on Medicaid during the pregnancy are automatically eligible for Medicaid at time of birth.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program. Indiana's SCHIP is comprised of: Phase I SCHIP - Uninsured children below the age of nineteen with family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients. Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy**	**Does your MCH program have Direct access to the electronic database for**

	purposes in a timely manner? (Select 1 - 3)	analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	2	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	No

Notes - 2008

Narrative:
Notes - 2007

Narrative:
Indiana continues to work on linkages as specified in the following seven areas: annual linkage of infant birth and infant death certificates, annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files, annual linkage of birth certificates and WIC eligibility files, annual linkage of birth certificates and newborn screening files, a hospital discharge survey for at least 90% of in-State discharges, an annual birth defects surveillance system, and a survey of recent mothers at least every two years similar to the Prenatal Risk Assessment Monitoring Surveillance (PRAMS) survey.

The State Systems Development Initiative (SSDI) grant provides for oversight of the Data Integration and linkage projects through the Data Integration Steering Committee (DISC), the main output being the Operational Data Store (ODS). The ODS is the agency's main linkage mechanism. Progress has been made to such an extent that Indiana can now report successful linkage at least some of the time in all seven areas. MCSHC now has the ability to obtain data for program planning or policy purposes in a timely manner for all seven areas, and for birth certificate/death certificate information and the annual birth defects surveillance system MCSHC has that ability all of the time. Access to the electronic databases for analysis has also been achieved with regard to the Newborn Screening link, the birth defects surveillance system link,

and the survey of recent mothers (PRAMS like survey). The plan is to continue work on the ODS including both input links and output via specific Data Marts in 2006.

The attached document for 09a is the narrative for Indiana Health System Capacity Indicator 09c, a new measure dealing with obesity.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2008

Narrative:
Notes - 2007

Narrative:
Indiana high-school students are marginally more likely than their national counterparts to smoke cigarettes, according to the findings of the 2003 Indiana Youth Risk Behavior Survey conducted by the Indiana State Department of Health, MCSHC. Forty-eight high schools in the state and 1,674 students in grades 9 through 12 participated in the survey, which is part of a national study initiated by the Centers for Disease Control and Prevention to monitor student's health risks and behaviors.

2003 was the first time enough high schools in the state responded to the survey to allow the data collected to be weighted, that is, to be generalized for all Indiana high-school students. The Indiana Youth Risk Behavior Survey has been completed for 2005 with enough completed surveys to produce a weighted sample. Fewer Indiana teens are smoking.

The 2004 Indiana Youth Tobacco Survey (IYTS) shows that 21 percent of Hoosiers in grades 9-12 are smokers compared to 32 percent in 2000. This represents a 32 percent decline in smoking prevalence over the four-year period bringing Indiana's high school smoking rate below the national average. The Indiana Youth Tobacco Survey was conducted from November 2004 to January 2005 surveying more than 5,400 Indiana youth in grades 6-12 at 92 schools statewide. The survey included an over sample of African American and Hispanic youth.

Indiana Tobacco Prevention and Cessation (ITPC) programs adapted the Youth Tobacco Survey, developed by the Centers for Disease Control and Prevention, by adding questions designed for Indiana to serve as a surveillance measure for statewide tobacco use prevalence among youth. The full 2004 Indiana Youth Tobacco Survey Report is available at www.itpc.in.gov.

2005 YRBS Information: 53 High Schools, 1528 students grades 9-12 surveyed.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The mission statement of the Indiana State Department of Health (ISDH) is to "promote, protect, and provide for the public health of people in Indiana". The ISDH vision statement affirms, "The Indiana State Department of Health is committed to facilitation of efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to: promote integration of public health and health care policy; strengthen partnerships with local health departments; collaborate with hospitals, providers, governmental agencies, business, insurance, industry, and other health care entities; support locally-based responsibility for the health of the community. The ISDH's vision for the future is one in which health is viewed as more than the delivery of health care and public health services. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

In order to fulfill our mission, ISDH Maternal and Children's Special Health Care Services (MCSHC) continues to strive to meet the performance goals established by national initiatives such as MCHB's National Performance Measures as well as state initiatives, based on the latest needs assessment. The needs assessment results focused on the following health status indicators: Asthma Hospital Discharges, Medicaid/CHIP Screening, Prenatal Care Adequacy, Low/Very Low Birthweight, MCSHC Access to Data Sources, Fatal/Non-Fatal Injuries, Chlamydia Rates, Dental Screening, and Adolescent Tobacco Use.

The needs assessment results have dictated the focus of the State Priorities listed in the following section, "B. State Priorities". Program and resource allocation issues are determined using the State Priorities for guidance. Utilizing the MCH "pyramid", program and resource funding has been carefully allocated to cover not only the State Priorities but also to cover all four of the "pyramid levels".

Direct Health Care is being evaluated with performance measures (PM) for Newborn Screening, CSHCS Family Participation, and Asthma Hospitalization. Enabling Services PM include the CSHCS Medical/Health Home and decreasing tobacco use in prenatal smokers. Population-based PM address CSHCS Insurance, CSHCS Community Systems, CSHCS Transition Issues, Immunization Rates, Teen Birth Rates, Dental Sealants, Child Motor Vehicle Accidents, and Lead Screening. Infrastructure Building PM include Breastfeeding Improvements, Newborn Hearing Screening, Child Health Insurance, Medicaid Usage, Very Low Birth Weight, Teen Suicide, High Risk Deliveries, Prenatal Care, Data Integration, Prenatal Care for Black Women, Birth Spacing, and Overweight Rates among High School Students. State and National Performance Measures have been established and hold ISDH MCSHC accountable for the success (or failure) of each of these initiatives.

Outcome Measure data for Infant Mortality, Black/White Infant Mortality Disparity, Neonatal Mortality, Postneonatal Mortality, Perinatal Mortality, and the Child Death Rate are also monitored and reported annually.

Specifically, within the "pyramid" level of Direct Medical Services, ISDH MCSHC funds programs to provide genetics services, immunizations, dental sealants, sickle cell prophylactic medicine, lead poisoning prevention, direct medical care for pregnant women, infants, children, adolescents, family planning, STD screens, free pregnancy screens, as well as speciality medical services and primary care for CSHCN. Funded Enabling Services programs provide genetics services education, prenatal and family care coordination, newborn screening and referral, sickle cell management, prenatal substance use prevention program (PSUPP), Indiana Child Care Health Consultation Program (ICCHCP) and coordination with Medicaid and WIC in addition to many other programs.
Population- Based Services that are provided by ISDH MCSHC or funded by MCSHC include the

Indiana Family Helpline (IFHL), the Early Childhood Comprehensive Systems (ECCS) program, the Indiana Joint Asthma Coalition (InJAC), the adolescent pregnancy prevention initiative, sudden infant death prevention, dental fluoridation efforts, and fetal infant mortality review. ISDH Infrastructure Building Services include efforts such as the Indiana Perinatal Network; the MCH, NBS and PSUPP data systems; the integration of data systems to facilitate the Indiana Birth Defects and Problems Registry (IBDPR), the Genomics in Public Health and Newborn Screening education efforts and other data analysis efforts for planning and reporting; policy and standards development; planning, evaluation, and monitoring; and quality assurance to MCSHC grantees.

Progress toward the achievement of our National and State performance goals is reported in Sections C and D, following. ISDH MCSHC continues to build on previous year's successes. This year's Annual Report reflects that for 2004, ISDH MCHSC met eight of the thirteen National performance measures for which FY 2004 data is available, and six of the seven previous State-Negotiated performance measures have been met. Progress could not be reported on the five performance measures that are reported through the CSHCN survey, as current data is not available. Of the five national performance measures and the state-negotiated performance measure that were not actually met, most were close.

MCSHC is proposing a new set of State Negotiated Performance Measures (SP) based on the results of the needs assessment. Several of the new SP are identical to the previous SP, only the number has been changed. Others are similar in the need addressed, but the measure has been changed to keep up with MCSHC progress in addressing that need. There are three entirely new proposed SP and some of the previous SP are being discontinued. These are enumerated in Sections B and D./2007/Final FY 2005 activities for the SP that are being discontinued are in section D, at the beginning of related (for the most part) new SP. In 2006, ISDH MCSHC met or exceeded 9 performance measures, did not meet but came close to meeting 8 performance measures and recorded progress on another 9 performance measures that were in transition.//2007//
/2008/ Final FY2006, ISDH MCSHC met or exceeded 14 performance measures, did not meet but came close to meeting 9 performance measures and recorded progress on another 3 performance measures.//2008//

B. State Priorities

Indiana experiences high rates of low birthweight, infant mortality, and inadequate prenatal care with greater disparity among minority populations. Childhood immunizations, while significantly improving, are still below HP2010 targets and environmental hazards, such as lead and second hand smoke, threaten the health of tens of thousands of children and adults.

Risky behaviors among adolescents lead to teen pregnancy and childbearing, and high rates of tobacco use. Obesity among children and adults contributes to higher incidences of chronic diseases like diabetes and cardiovascular diseases that contribute to escalating health care costs.

A high priority must be given to expanding the availability of care for isolated rural residents and underserved urban and suburban persons and to assisting the MCH populations' access to needed services, including the continued need to identify early and link children with special health care needs to appropriate services. At the same time, broad based education and outreach is needed to improve knowledge of healthy practices among the entire population.

The top priority needs identified in Indiana are:
1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality.
2. To reduce both qualitative and quantitative barriers to access to health care, mental health care and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women and families.
3. To build and strengthen systems of family support, education and involvement to empower

families to improve health behaviors.
4. To reduce morbidity and mortality rates from environmentally related health conditions including asthma, lead poisoning and birth defects.
5. To decrease tobacco use in Indiana.
6. To integrate information systems which facilitate early identification and provision of services to children with special health care needs.
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior including teen pregnancy, unhealthy dietary behaviors and physical inactivity.
8. To reduce obesity in Indiana.
9. To reduce the rates of domestic violence to women and children, child abuse and childhood injury in Indiana.
10. To improve racial and ethnic disparities in women' of childbearing age, mothers', and children's health outcomes.

ISDH MCSHC Now reports on 8 State Negotiated Performance Measures (SP):
SP 01 The number of data sets, including the NBS, UNHS, Lead, Indiana Birth Defects and Problems Registry, Immunizations, CSHCS, and First Step Data, that are completely integrated into the Indiana Child Health Data Set. (Similar to previous SP 09)
SP 02 The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less than five years old. (Previously SP 10)
SP 03 The percent of live births to mothers who smoke. (Previously SP 11)
SP 04 The percent of black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate. (Previously SP 12)
SP 05 The percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter. (Similar to previous SP 14)
SP 06 The proportion of births occurring within 18 months of a previous birth. (New)
SP 07 The number of community/neighborhood partnerships established in 5 targeted counties to identify perinatal disparities so that appropriate responses can be implemented at the local level to lessen these differences. (New)
SP 08 The percentage of high school students who are overweight. (New)

The identified priority needs will be impacted by activities in the listed Performance Measures as follow:
Priority 1 is addressed in PM 01, PM 08, PM 15, PM 17 & PM 18 and SP 01, SP 03, SP 04, SP 06 & SP 07
Priority 2 is addressed in PM 02, PM 03, PM 04, PM 05, PM 06, PM 07, PM 09, PM 13, PM 14 & PM 19 and SP 04 & SP 07
Priority 3 is addressed in PM 02, PM 03, PM 04, PM 05, PM 06 & PM 11 and SP 04, SP 05, SP 06, SP 07 & SP 08
Priority 4 is addressed in PM 01, PM 12, PM 17 & PM 18 and SP 01, SP 02, SP 03 & SP 05
Priority 5 is addressed in SP 03
Priority 6 is addressed in SP 01
Priority 7 is addressed in PM 08, PM 10 & PM 16
Priority 8 is addressed in SP 08
Priority 9 is addressed in PM 08 & PM 16
Priority 10 is addressed in PM 01 - 18 and SP 01 - 05 (All of them)

NOTE: In 2007 the definitions for Federal PM 14 and 15 changed significantly. These two PM now address different priorities:

PM 14 -- Priorities 1, 2, 3, 6, 7, and 8
PM 15 -- Priorities 1, 2, 3, 4, 5, and 10

MCSHC grants approximately $7.5 million to fund more than 50 local and statewide projects that build infrastructure and provide population-based, enabling and direct services to meet these

objectives. Additionally, beginning in FY 2005, MCSHC has provided approximately $1 million in one-time infrastructure grant funds to more than 30 local and statewide projects to conduct community needs assessment, operate pilot projects or otherwise address the priority needs and performance measures above.

/2007/Because of reductions in Title V allocations and increased costs, MCSHC is reducing grant funding from $8.5 million in FY 2006 to $6.5 million in FY 2007. This requires early termination of most of the one-time Special Projects initiated in FY 2005 and reductions of 6% to 11% for existing service providers. Special Projects being cut include obesity prevention and lead poisoning prevention. However, MCSHC has added obesity prevention performance measures to service provision requirements for most currently funded service providers and is also providing information about lead screening requirements and medical management recommendations for children ages 6 to 84 months to all currently funded service providers.

Additionally, MCSHC projects some cost savings for Family Planning provision by combining Title V and Title X Family Planning services. MCSHC will provide all Title V Family Planning services through a grant to the Indiana Family Health Council, the delegate for all Title X funding for Indiana.//2007///***2008/ MCSHCS is working toward distributing the Title XX and TANF family planning funding in FY 2009//2008//***

Activities of MCSHC staff and grantees to meet these performance measures are discussed in sections C and D below.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	99	99	99	99.2	100
Annual Indicator	99.4	100	100	100.0	100.0
Numerator				111	205
Denominator				111	205
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
When this performance measure changed, we had, and maintained, a 100% rate of follow-up in all screen positives. We were using this to report percentage of children screened, which this measure formerly had been.

Notes - 2004
When this performance measure changed, we had, and maintained, a 100% rate of follow-up in all screen positives. We were using this to report percentage of children screened, which this measure formerly had been.

a. Last Year's Accomplishments

a. Last Year's Accomplishments

a. FY 2006 Accomplishments

FY 2006 Performance Objective: Maintain at 100% the percent of newborns that are screened for Indiana mandated conditions and receive appropriate follow-up and referral as defined by Indiana's Newborn Screening Program.

Status: In CY 2006, 100% of infants who were screened and confirmed with conditions received appropriate follow-up and referral.

Activities that impacted this performance were:

The Newborn Screening Program (NBS) began developing the NBS datamart through the Operational Data Store (ODS). The Newborn Screening (NBS) Program developed the Sickle Cell datamart and began the Early Hearing Detection & Intervention (EHDI) datamart in FY 2006.

NBS followed up on all abnormal screening results to completion and determined them to be either negative or confirmed positive with treatment initiated.

NBS ensured referral of children with positive screens to one or more of the following: Metabolic Genetics, Endocrinology, Sickle Cell Centers, First Steps and CSHCS programs.

The NBS Director worked with the NBS Advisory Committee. A Cystic Fibrosis Task Force was convened in September to plan for the inclusion of CF in the NBS panel by October 2007.

In CY 2006, NBS provided five (5) in-service trainings to Public Health Nurses and twenty-four (24) hospitals and birthing facilities.

NBS started developing a training presentation and training materials for midwives to increase their birth reporting and to encourage their promotion of newborn screens to clients.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. NBS will continue to follow-up on all invalid, abnormal and positive test results until they are complete and negative or the babies are receiving treatment.			X	
2. 2. NBS will continue to refer infants with confirmed positive results to the Genetics, Endocrinolgy or Metabolic Clinics at Indiana University Medical Center, Sickle Cell clinics, First Steps, and the CSHCS programs.			X	
3. 4. NBS will continue to provide in-service training to Public Health Nurses, hospitals, and birthing centers.				X
4. 5. NBS will develop an in-service training program for midwives to increase their birth reporting and to encourage their promotion of newborn screens to clients.				X
5. 5. NBS will add Cystic Fibrosis to the NBS panel by October 1, 2007				X
6.				
7.				
8.				
9.				

10.				

b. Current Activities
b. Current Activities
b. Current Activities
FY 2007 Performance Objective: Maintain at 100% the percent of newborns that are screened for Indiana mandated conditions and receive appropriate follow-up and referral as defined by Indiana's Newborn Screening Program.

Activities to impact this performance objective include:

Newborns whose screens were invalid, abnormal, or positive continue to receive follow-up.

To date, 100% of infants with confirmed positive results were referred to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the CSHCS programs.

NBS continues to provide in-service training to Public Health Nurses, midwives, hospitals, and birthing centers. An updated presentation for Public Health Nurses is near completion for implementation online.

NBS will begin the development of the NBS (heel-stick) Datamart and integration of the Operational Data Store for tracking and follow-up of babies not receiving heel-sticks and receiving positive heel-sticks.

c. Plan for the Coming Year
c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: Maintain at 100% the percent of newborns that are screened for Indiana mandated conditions and receive appropriate follow-up and referral as defined by Indiana's Newborn Screening Program.

Activities to impact this performance objective include:

NBS will continue to follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.

NBS will continue to refer infants with confirmed positive results to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the Children's Special Health Care Services (CSHCS) programs.

NBS will continue to provide in-service training to Public Health Nurses, hospitals, and midwives, and birthing centers.

NBS will complete the development of the NBS (heel-stick) Datamart and integration of the Operational Data Store (ODS) for tracking and follow-up of babies not receiving heel sticks and receiving positive heel-sticks.

NBS will add Cystic Fibrosis to the NBS panel by October 1, 2007.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective		61.1	63	63	63
Annual Indicator	61.1	61.1	61.1	61.1	61.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	64	64	64	64	64

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY2006 Accomplishments
FY 2006 Performance Objective: The percent of children with special health care needs ages 0 to 18, whose families partner in decision-making at all levels, who were satisfied with the services they receive will be determined based on State and Local Area Integrated Telephone Survey (SLAITS) data, for which FY06 results are not yet available.

Status: Automatically calculated by the Federal Government from the State and Local Area Integrated Telephone Survey (SLAITS) data; not yet available.

Activities that impacted this performance were:

The activity to translate program letters into Spanish for the Children's Special Health Care Services Program (CSHCS) was completed. Work is still in progress by CSHCS to add these letters to the Agency Claims and Administrative Processing System (ACAPS) to send to the program's Spanish-speaking participants.

CSHCS developed a satisfaction survey for parents/guardians of the program's participants to determine how they feel services can be improved.

CSHCS reviewed and updated the CSHCS Participants Manual. This manual is being further updated and has not yet been distributed. CSHCS also produced a Spanish language version of the Participants Manual in 2006 which has not yet been finalized or distributed.

CSHCS has a grant with ASK (About Special Kids), formerly known as Indiana Parent Information Network (IPIN), which supports children with special needs and their families by providing information, peer support and education and building partnerships with professionals and communities. Activities include the following:

A telephone help line was made available to families for questions relating to healthcare coverage, health care providers, education, early intervention, training and other issues. During FY 06, 1593 calls were taken.

The ASK newsletter, which provides information about child care, community resources, health care financing, genetics and education law, was sent to families of children enrolled in CSHCS.

Parent Liaisons completed over 5500 phone calls to provide initial peer support to families of children with special healthcare needs and made over 5500 follow-up calls.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. CSHCS will analyze satisfaction survey responses to determine better ways to involve families in the decision making of their child's health care as well as program policy decisions.				X
2. 2. CSHCS will continue to evaluate currently funded CSHCN programs to determine how well they meet this performance measure.				X
3. Medical Director will be working with ISDH Disaster Preparedness to assure needs of CSHCN are included.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY2007 Current Activities

FY2007 Performance Objective: The percent of children with special health care needs ages 0 to 18, whose families partner in decision-making at all levels, who were satisfied with the services they receive will be determined based on SLAITS data, for which FY07 results are not yet available.

Activities to impact this performance objective include:

The activity to translate program letters into Spanish for the Children's Special Health Care Services Program (CSHCS) was completed. Work is still in progress by CSHCS to add these letters to the Agency Claims and Administrative Processing System (ACAPS) to send to the program's Spanish-speaking participants.

CSHCS developed a satisfaction survey for parents/guardians of the program's participants to determine how they feel services can be improved. This survey has been distributed. Twenty-eight % of the surveys sent out were responded to, and of that 28%, over 84% listed their experience as good or great, with over 57% saying Great. Only 1% of all respondents rated their experience as Poor/Bad.

CSHCS distributed the FEMA brochure, "Preparing for Disaster for People with Disabilities and other Special Needs", to all participants in 2007.

CSHCS mailed notices of the "Inspiring Abilities Expo 2007," to all participants in Hancock and surrounding counties. This event was held 3/10/07 in Greenfield, Indiana, and provided an opportunity for families to connect with service providers.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for 2008
FY 2008 Performance Objective: The percent of children with special health care needs, ages 0 to 18 whose families partner in decision-making at all levels, who will be satisfied with the services they receive, will remain at 64% based upon SLAITS data.

Activities to impact this performance objective include:

CSHCS will continue work on the project to add the program letters, which were translated into Spanish, to the Agency Claims and Administrative Processing System (ACAPS) to send to the program's Spanish-speaking participants.

CSHCS will finalize its review and update of the CSHCS Participants Manual. CSHCS will mail every program participant a new copy of the updated manual in FY 08.

CSHCS also produced a Spanish language version of the Participants Manual in 2006 which has not yet been finalized or distributed. CSHCS plans to mail these manuals in FY 08.

CSHCS is in the process of completing a renewal grant with ASK (About Special Kids) which supports children with special needs and their families by providing information, peer support and education and building partnerships with professionals and communities. Planned activities will include the following:

The telephone help line will continue to be made available to families for questions relating to healthcare coverage, health care providers, education, early intervention, training and other issues.

ASK will provide advisory support to ISDH programs and policies and review communication being sent to families on request.

ASK is continuing work on an e-newsletter and collecting email addresses through their database. To date, they have 870 families and medical professionals on the e-newsletter list, but plan to increase this amount and develop this project further in FY08.

Medical Director will be working with ISDH Disaster Preparedness to assure needs of CSHCN

are included.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective		55.7	56	56	56
Annual Indicator	55.7	55.7	55.7	55.7	55.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	56	57	57	57	57

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home will be maintained at 56% in FY 2006.

Status: In CY 2006, 56% of CSHCN in Indiana have a "medical/health" home.

Activities that impacted this performance were:

MCSHC continued to develop the Universal Newborn Hearing Screening (UNHS) and Sickle Cell program datamarts within the Operational Data Store (ODS) in order to track clients in these programs.

MCSHC began to update the Medical Passports for use in Children with Special Health Care Services (CSHCS).

The Indiana Parent Information Network (IPIN), now known as About Special Kids (ASK), and Unified Training Services (UTS) provided two physician medical home training programs in

communities statewide. Due to UTS and IPIN staff changes additional trainings were postponed until FY 2007.

MCHSC developed an educational brochure for parents regarding Medical Home to include in mailings to consumers from the NBS, CSHCS, and Indiana Family Helpline (IFHL) programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. MCSHC will continue to use the Operational Data Store (ODS) information provided by the Newborn Screening (NBS), Universal Newborn Hearing Screening (UNHS), and Sickle Cell programs to track primary care providers for clients in these programs				X
2. 2. MCSHC will continue to market the Medical Passports for use in Children with Special Health Care Service (CSHCS).				X
3. 3. The Indiana Parent Information Network (IPIN) and Unified Training Services (UTS) will provide four physician medical home training programs in communities statewide.				X
4. 4. MCSHC will distribute an educational brochure for parents regarding Medical Homes.			X	
5. 5. MCSHC will evaluate five projects that are providing Medical Home models in regards to meeting the Children and Youth Special Health Care Needs (CYSHCN) performance measures.				X
6. 6. MCSHC will develop a strategic plan focusing on integrating services for CYSHCN including objectives on Medical Home.				X
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home will be maintained at 56% in FY 2007.

Activities to impact this performance objective include:

MCSHC will complete the Universal Newborn Hearing Screening (UNHS) and Sickle Cell program datamarts within the Operational Data Store (ODS) and begin developing the Newborn Screening datamart. These datamarts will allow the NBS staff to better track clients in these

programs.

MCSHC will complete the updates and begin marketing the Medical Passports for use in Children with Special Health Care Service (CSHCS).

About Special Kids (ASK) has provided six medical home training programs at two Indianapolis clinics for physicians in communities.

MCSHC will develop and distribute an educational brochure for parents regarding Medical Homes to include in mailings to consumers from the NBS, CSHCS, and Indiana Family Helpline (IFHL) programs.

MCSHC hired a manager in May 2007 whose focus will be on integrating services and medical home for children with special health care needs.

MCSHC will begin evaluating five projects that are providing Medical Home models to determine how they are meeting the Children and Youth Special Health Care Needs (CYSHCN) performance measures.

MCSHC will develop a strategic plan to integrate community services for CYSHCN including objectives on Medical Home.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home will be maintained at 56% in FY 2008

MCSHC will continue to market the Medical Passports for use in Children with Special Health Care Service (CSHCS).

About Special Kids (ASK) will continue to provide medical home training programs for physicians in communities statewide.

MCSHC will select or develop a brochure for physicians about the medical home concept.

MCSHC will continue to evaluate five projects that are providing Medical Home models to determine how they are meeting the Children and Youth Special Health Care Needs (CYSHCN) performance measures.

MCSHC will complete the development of a strategic plan and begin to integrate services for CYSHCN including objectives on Medical Home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		63.3	65	65	67
Annual Indicator	63.3	63.3	63.3	63.3	63.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	67	69	69	69	69

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be 67% in FY 2006. Actual figures, based upon information in the Agency Claims and Administrative Processing System (ACAPS), of participants who have either private or public health insurance is 89.97%. Of that total percentage, 51.38% of participants have some kind of private health insurance and 38.59% have Medicaid.

Activities that impacted this performance were:

CSCHS developed material to distribute to participants to help them understand the need to utilize and keep their insurance and the need to disclose it whenever services are rendered. A newsletter was developed but was not issued. However, participant brochures were mailed to participants and given to facilities to distribute to applicants or participants.

CSHCS updated the Provider Manual to include more information about requirements to bill all other available insurance before CSHCS is billed. This update includes language to encourage providers to work with families so they understand how insurance affects the provider of service. Some work was done on updating the provider manual, however, this activity was not completed.

CSGCS developed new capacities within ACAPS so that insurance information can be shared more easily with providers and families, and so that it can be kept up to date and within program areas that work directly with provider and participants. This activity was not completed due to other priorities.

CSHCS assessed the viability of on-line enrollment forms, on a web-based system. Work

continues on developing an online application to be used for multiple programs. This activity is not complete.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Children's Special Health Care Services (CSHCS) will track insurance utilization in the Agency Claim and Administrative Processing System (ACAPS).				X
2. 2. CSHCS will monitor the activities and progress of the Health Insurance for Indiana Families Committee, a group of state leaders charged with developing no- or low-cost options to provide services for the uninsured.				X
3. 3. CSHCS will monitor the activities and progress of Covering Kids & Families (CKF), a national initiative funded by the Robert Wood Johnson Foundation to increase the number of children and adults who benefit from federal and state health care cove				
4. 4. CSHCS will evaluate currently funded Children with Special Health Care Needs (CSHCN) programs to see how well they assist families in finding resources for necessary services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. 2007 Current Activities

FY 2007 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be maintained 67% in FY 2007. FY 07 figures are not yet available, but actual FY 06 figures, based upon information in the Agency Claims and Administrative Processing System (ACAPS), of participants who have either private or public health insurance is 89.97%. Of that total percentage, 51.38% of participants have some kind of private health insurance and 38.59% have Medicaid.

Activities to impact this performance objective include:

CSHCS will track insurance utilization in ACAPS. This activity is current and continues to allow for denial of claims for which other insurance coverage is available.

CSHCS will monitor the activities and progress of Covering Kids & Families (CKF), a national initiative funded by the Robert Wood Johnson Foundation to increase the number of children and adults who benefit from federal and state health care coverage programs. The Director of CSHCS serves on the board of (CFK).

CSHCS will evaluate currently funded Children with Special Health Care Needs (CSHCN) programs to see how well they assist families in finding resources for necessary services.

c. Plan for the Coming Year
c. Plan for the coming Year
c. Planned Activities for FY2008
FY 2008 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will increase to 69% in FY 2008.
Insurance information for FY 06 indicates the CSHCS program has exceeded that percentage of participants who carry private or public health insurance. Our goal is to maintain at least 69% or greater.

Activities to impact this performance objective include:

CSHCS will be updating ACAPS to utilize insurance information for processing electronic pharmacy claims.

CSHCS will be sending information to providers which clarifies our reimbursement methodology as it relates to other insurance and the maximum allowable payment.

CSHCS is in the process of updating both the Provider and Participant Manual and will be issuing these revised manuals later in this year.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective		79.5	80	80	80
Annual Indicator	79.5	79.5	79.5	79.5	79.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	82	82	82	82

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: 80% of families with CSHCN age 0 to 18 will report the community-based services systems are organized so they can use them easily.

Status: Incomplete

Activities that impacted this performance were:

Children's Special Health Care Services (CSHCS) updated program information on the CSHCS website.

MCSHC maintained an 800 Family Help Line with V/TDD capabilities and bilingual support and refers families to community-based services.

CSHCS provided current community based training to First Steps providers and Division of Family and Children (DFC) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.

CSHCS funded and collaborated with About Special Kids (ASK) and its statewide network of family-to-family peer support.

CSHCS reimbursed families for in-state and out-of-state transportation of participants to medical facilities for services.

CSHCS provided outreach to Neonatal Intensive Care Units (NICU), and maintained and provided lists of primary care physicians participating in the CSHCS program.

CSHCS promoted Single Points of Entry (SPOE) early intervention sites, using local Offices of Family Resources to take CSHCS applications.

CSHCS used a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintained an information and application site at Riley Hospital for Children.

CSHCS Participant Manual has been updated. It will be printed and mailed to each program participant.

CSHCS published a bi-yearly (Spring and Fall) newsletter that included any program updates that would affect participants (i.e., policy changes, new mileage reimbursement rates, etc.)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. CSHCS will provide current community based training to First Steps provider and the Division of Family and Children (DFC) providers to promote systems development, and to improve the organization and delivery of services to CSHCN.				X

2. 2. CSHCS will maintain an 800 Family Help Line with V/TDD capabilities and bilingual support and refers families to community-based services.			X	
3. 3. CSHCS will fund and collaborate with Indiana Parent Information Network (IPIN) and its statewide network of family-to-family peer support.			X	
4. 4. CSHCN will continue to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.		X		
5. 5. CSHCS will provide outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.				X
6. 6. CSHCS will promote Single Points of Entry (SPOE) early intervention sites, using local Offices of Family and Children to take CSHCS applications.				X
7. 7. CSHCS will continue using a customer service representative on an “as needed” basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital for Children.		X		
8. 8. CSHCS will publish a bi-yearly (Spring and Fall) newsletter which includes any program updates that affect participants.			X	
9. 9. CSHCS will evaluate currently funded Children with Special Health Care Needs (CSHCN) programs to see how well they assist families in using community based services.				X
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: 80% of families with CSHCN age 0 to 18 will report the community-based services systems are organized so they can use them easily.

Status: Pending

Activities to impact this performance objective include:

MCSHC will maintain an 800 Family Help Line with V/TDD capabilities and bilingual support and refer families to community-based services.

CSHCS will provide current community based-training to First Steps providers and Division of Family and Children (DFC) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.

CSHCS will fund and collaborate with About Special Kids (ASK) formerly Indiana Parent Information Network (IPIN), and its statewide network of family-to-family peer support.

CSHCS will continue to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.

CSHCS will provide outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.

CSHCS will promote Single Points of Entry (SPOE) early intervention sites, using local Offices of Family Resources to take CSHCS applications.

c. Plan for the Coming Year
c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: 82% of families with CSHCN age 0 to 18 will report the community-based services systems are organized so they can use them easily.

Activities to impact this performance objective include:

MCSHC will maintain an 800 Family Help Line with V/TDD capabilities and bilingual support and refer families to community-based services.

CSHCS will provide current community based-training to First Steps providers and Division of Family and Children (DFC) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.

CSHCS will fund and collaborate with About Special Kids (ASK) and its statewide network of family-to-family peer support.

CSHCS will continue to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.

CSHCS will provide outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.

CSHCS will promote Single Points of Entry (SPOE) early intervention sites, using local Offices of Family Resources to take CSHCS applications.

CSHCS will continue using a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital for Children.

CSHCS will publish a bi-yearly (Spring and Fall) newsletter which includes any program updates that affect participants (i.e., policy changes, new mileage reimbursement rates, etc.).

CSHCS will begin evaluate currently funded Children with Special Health Care Needs (CSHCN) programs to study how well they assist families in using community based services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		5.8	6	6	6
Annual Indicator	5.8	5.8	5.8	5.8	5.8

Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6	7	7	8	8

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: 6% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life (CSHCN Survey).

Status: Incomplete

Activities that impacted this performance were:

CSHCS published a newsletter to CSHCN families and participants with listings for community resources and support systems.

CSHCS used the Agency Claims and Administrative Processing System (ACAPS) to target and generate mailing lists for adolescents appropriate to their age categories and potential topics of interest.

The Children and Youth with Special Health Care Needs (CYSHCN) transition clinic developed transition assistance for clients and training for providers.

MCSHC recommended to ISDH administration full funding for the Riley Hospital / Indiana University CYSHCN Transition Project.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. CSHCS staff will receive ongoing training and updates				X

regarding transitioning CSHCN to adult life.				
2. 2. CSHCS will publish a newsletter to CSHCN families and participants with listings for community resources and support systems.			X	
3. 3. CSHCS will use the Agency Claims and Administrative Processing System (ACAPS) to target and generate mailing lists for adolescents appropriate to their age categories and potential topics of interest.				X
4. 4. CSHCS and CSHCN transition clinic will develop transition assistance for clients and training for providers.				X
5. 5. CSHCS will work with interagency initiatives regarding transition for disabled individuals from school to work or youth to adult health services.				X
6. 6. The CYSHCN Transition Project will work with health care providers statewide on transitioning youth with special health care needs to adult care.			X	
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. 2007 Current Activities

FY 2007 Performance Objective: 8% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life (CSHCN Survey). UNDERWAY

Activities to impact this performance objective include:

Children's Special Health Care Services (CSHCS) is developing and distributing a Transition Manual to 100% of participants, age 12-21.

Children's Special Health Care Services (CSHCS) staff will receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life. PR

CSHCS will publish a newsletter to CSHCN families and participants with listings for community resources and support systems.

CSHCS will use the Agency Claims and Administrative Processing System (ACAPS) to target and generate mailing lists for adolescents appropriate to their age categories and potential topics of interest.

Children and Youth with Special Health Care Needs (CYSHCS) is working with interagency initiatives regarding transition for disabled individuals from school to work or youth to adult health services.

The Children and Youth with Special Health Care Needs (CYSHCN) Transition Project has been initiated and is developing protocols for transitioning youth with special health care needs to adult care.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: 8% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life (CSHCN Survey).

Activities to impact this performance objective include:

Children's Special Health Care Services (CSHCS) will develop and distribute a Transition Manual to 100% of participants, age 12-21.

Children's Special Health Care Services (CSHCS) staff will receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life.

CSHCS will publish a newsletter to CSHCN families and participants with listings for community resources and support systems.

CSHCS will use the Agency Claims and Administrative Processing System (ACAPS) to target and generate mailing lists for adolescents appropriate to their age categories and potential topics of interest.

CSHCS and CSHCN transition clinic will develop transition assistance for clients and training for providers.

CYSHCS will work with interagency initiatives regarding transition for disabled individuals from school to work or youth to adult health services.

The CYSHCN Transition Project will work with health care providers statewide on transitioning youth with special health care needs to adult care.

Materials and tools developed at the CYSHCN transition clinic will be distributed to other providers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	82	83	80	81	81
Annual Indicator	78.5	79.5	79.0	81	83.2
Numerator	201453	203559	200692		
Denominator	256710	256084	254041		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2007	2008	2009	2010	2011
Annual Performance Objective	84	84	85	85	86

Notes - 2006
Source of data: ISDH Immunization Program.

Figure used is the lowest of the figures provided by the ISDH Immunization program for this group of immunizations and this age range. Individual numerator and denominator figures were not provided; however, we expect to receive those later in the year.

Objectives for 2007 and forward have been revised upwards due to FY2006 success.

Notes - 2005
2005 data not yet available. Estimate provided based on trend analysis.
Future objectives have been revised incase estimate is not met.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percent of 19 to 35 month olds who have received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will be maintained at 81% in 2006.

Status: Achieved 81.4% - Twenty-four (24) of the 40 MCH funded clinics that administer immunization were above the 81% level.

Activities that impacted this performance were:

All MCSHC funded sites that deliver immunization services received both Vaccines for Children (VFC) vaccine (for VFC eligible children) and Public Health Service Section (PHS) 317 funded vaccine for all other children.

All MCSHC grantees providing immunizations to more than 25 children in the 19 to 35 month old age group received an Operational Program Review this year, Clinic Assessment Software Application and follow-up (CASA/AFIX) to determine their immunization rate of this age group.

All MCSHC grantees were encouraged to conduct reminder/recall activities to bring children into their facilities to receive appropriate vaccinations. Grantees could have used the Children and Hoosiers Immunization Registry Program CHIRP reminder/recall capabilities. This was done at the 2006 Operational Program Review (OPR's).

The ISDH Immunization Program worked with MCH sites to increase participation in CHIRP (Children and Hoosiers Immunization Registry Program) to 75% in 2006. However, only 58% of MCH sites were enrolled in CHIRP as identified in the 2006 Operational Program Review (OPR's).

Indiana Family Helpline provided education and referrals to callers. IFHL referred immunization related calls to Immunization Program staff as needed.

MCSHC Health Systems Development (HSD) staff participated on the Immunization Program Advisory Committee. The name has change to Indiana Immunization Coalition.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. The ISDH Immunization Program will continue to provide all Advisory Committee on Immunization Practices (ACIP) recommended vaccines to all MCH sites.				X
2. 2. The ISDH Immunization Program will conduct Clinic Assessment Software Application and follow-up (CASA/AFIX) and on-site review visits at all MCH sites.				X
3. 3. The ISDH Immunization Program will work with MCH sites to increase the number of sites using reminder/recall systems for needed immunizations to 75%.				X
4. 4. The Immunization Program will work with the MCH Program to integrate the Federal Resource and Enabling Data system (FRED) with CHIRP.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: The percent of 19 to 35 month olds who have received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will increase to 84% in 2007.

Activities to impact this performance objective include:

The ISDH Immunization Program will continue to provide all Advisory Committee on Immunization Practices (ACIP) recommended vaccine to all MCSHC sites.

The ISDH Immunization Program will conduct Clinic Assessment Software Application and follow-up (CASA/AFIX) and on-site review visits at all MCSHC sites.

The ISDH Immunization Program will work with MCSHC to increase the number of sites using reminder/recall systems of needed immunizations to 75%.

The Immunization Program will work with MCSHC to integrate the Federal Resource and Enabling Data system (FRED) with CHIRP (Children and Hoosiers Immunization Registry Program) so that all MCSHC served children's immunization records will be in CHIRP.

MCSHC provided funds for the immunization program to provide additional needed vaccines for children.

c. Plan for the Coming Year

c. Plan for the Coming Year

c. Planned Activities for FY 2008

FY 2008 Performance Objective: The percent of 19 to 35 month olds who have received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria,

Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will increase to 84% in 2008.

Activities to impact this performance objective include:

The ISDH Immunization Program will continue to provide all Advisory Committee on Immunization Practices (ACIP) recommended vaccine to all MCSHC sites.

The ISDH Immunization Program will conduct Clinic Assessment Software Application and follow-up (CASA/AFIX) and on-site review visits at all MCSHC sites.

The ISDH Immunization Program will work with MCSHC to increase the number of sites using reminder/recall systems of needed immunizations to 75%.

MCSHC Health Systems Development (HSD) staff will participate on the Indiana Immunization Coalition.

The legislature increased cigarette tax by 44 cents of which a portion will be used to buy vaccines.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	25	23	22	20	19.5
Annual Indicator	22.5	21.5	20.9	20.5	
Numerator	2931	2817	2749	2757	
Denominator	130141	130897	131532	134457	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	19	18.5	18	17.5	17.5

Notes - 2006
No data available for FY2006 at this time. We are in process of acquiring FY2006 data and hope to have that data later in the year.

Notes - 2005
Objective changed 19.9, but web program would not allow change.

Source: U.S. Census Bureau, ISDH ERC

Notes - 2004

Objective changed to 21, but web program would not allow change.

Source: U.S. Census Bureau, ISDH ERC

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Objective: The birth rate for teenagers aged 15-17 will decrease to 19.5 in FY 2006. The birth rate for teens aged 15-17 was 20.9 per 1,000 females in the year 2004.

Status: Not Achieved (20.9%)

Activities that impacted this performance were:

State Adolescent Health Coordinator (SAHC) developed and submitted the FY 06 Federal Abstinence Education Grant. With the funding received, the State supported 26 grantees to implement abstinence education programs within their communities. A media campaign promoting abstinence to reduce teen pregnancy was also maintained and reached audiences state-wide.

SAHC provided technical assistance to all local Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT) grantees and to interested agencies across the state regarding topics such as grant writing, adolescent programming, Youth Risk Behavior Survey (YRBS), and youth development.

SAHC monitored the progress and effectiveness of the Abstinence Education Media Campaign. SAHC facilitated dissemination of all new media materials to agencies statewide to assure that the public was made aware of the availability of the materials. SAHC assisted in the authoring and creation of new educational materials for the abstinence education media campaign including a teen brochure on abstinence and a parent booklet with tips on how to talk to teens about sex and its consequences. SAHC worked with (and continues to work with) an advertising agency to update the Indiana RESPECT website. This update made the website more user friendly, interactive, and engaging for teens.

SAHC facilitated the Spring 2006 release of the 2005 YRBS national comparison data. The data generated newspaper releases regarding findings from this survey among students. ISDH had a press release regarding the data for the YRBS. Local media also picked up the story on the release of the YRBS data.

Maternal and Children's Special Health Care (MCHSC) funded school-based health centers provide either prenatal care coordination on-site or referral for prenatal care coordination for any pregnant student. SAHC served as the liaison between the school centers and MCHSC. SAHC contacted each school-based health center quarterly to learn more about the types of services being provided, provide technical assistance, and offer educational materials.

MCHSC enabled Free Pregnancy Test Program (FPT) agencies to provide counseling and referrals to health care providers, or provide abstinence or family planning information to sexually active teens with negative pregnancy tests. FPT is offered at all funded school based health centers and most MCSHC clinics.

SAHC promoted the 2006 National Day to Prevent Teen Pregnancy. Materials were sent out to all middle schools, high schools, and private schools in Indiana as well as an announcement with a link posted on the ISDH and Department of Education websites. ISDH had a press release detailing teen pregnancy rates for Indiana and the importance of informing teens about the consequences of sexual activity.

SAHC collaborated with the Coordinated School Health Program Director on the INSight (Indiana's Network of Students Inspiring Good Health Today) Youth Corps program. SAHC was approached to assist in planning a Youth Summit for adolescents and teens throughout the state in collaboration with the Coordinated School Health Program (both at ISDH and DOE) and the Indiana Coalition to Improve Adolescent Health.

SAHC served on the Coordinated School Health Program Intra-Agency workgroup.

SAHC resigned effective January 31, 2006. The administrative manager served as the Acting Coordinator until the position was filled. The position was vacant for nearly six months until a new SAHC was hired and began on June 19, 2006.

SAHC worked to gain approval internally at ISDH to develop an adolescent health coalition whose goal would be to author the first state adolescent health plan. Approval was granted in early September. The first meeting of interested parties to serve as part of the Indiana Coalition to Improve Adolescent Health was scheduled for early October, 2006.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. The State Adolescent Health Coordinator (SAHC) will develop and submit the FY 07 Federal Abstinence Education Grant.				X
2. 2. With FY' 06/07 RESPECT community grant program contracts ending, the SAHC will oversee the FY' 08/09 Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT) community grant program application and review process.				X
3. 3. SAHC will continue to develop and disseminate media materials to Indiana teens, their parents, and MCH and RESPECT grantees.			X	
4. 4. SAHC will work with the Coordinated School Health Program and the INShape Indiana program to assist in survey administration and data dissemination activities for the 2007 Youth Risk Behavior Survey (YRBS.)				X
5. 5. SAHC will collaborate with the Coordinated School Health Program Director on the statewide INSight Youth Corps program.				X
6. 6. SAHC will work collaboratively with the Community Nutrition/Obesity Prevention program to address adolescent obesity/physical activity issues.				X
7. 7. SAHC will work with other local and state agencies to develop the State Adolescent Health plan.				X
8. 8. SACH will provide Youth Development technical assistance seminars to interested agencies around the state.				X
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 19.0 in FY 2007.

Activities to impact this performance objective include:

With Federal Abstinence Education Grant the State was able to continue support for 26 grantees to implement abstinence education programs within their communities. A media campaign promoting abstinence to reduce teen pregnancy is also being maintained to reach audiences state-wide. At this writing only three quarters of the fiscal year was funded and the contracts with the communities were cancelled.

With the FY 06/07 Indiana RESPECT community grant program contracts ending, the SAHC has overseen the FY 08/09 Indiana RESPECT community grant program application and review process. SAHC updated the grant application for Indiana RESPECT.

SAHC will continue to monitor the progress and effectiveness of the Abstinence Education Media Campaign. SAHC will continue to work to disseminate all new media and educational materials to agencies.

A technical assistance meeting was held for all interested applicants to provide instruction on writing the grant and to clarify or answer questions regarding the application components.

SAHC reviewed all applications (61 total received) and made funding recommendations for FY 08/09 grantees. If congress does not fund this program at the federal level, only state funded grantees will be contracted.

c. Plan for the Coming Year

c. Plan for the Coming Year

c. Planned Activities for FY 2008

FY 2008 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 18.5 in FY 2008.

Activities to impact this performance objective include:

State Adolescent Health Coordinator (SAHC) will develop and submit the FY 08 Federal Abstinence Education Grant if one is available.

SAHC will provide technical assistance to all local Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT) grantees and to interested agencies across the state regarding topics such as grant writing, adolescent programming, Youth Risk Behavior Survey (YRBS), and youth development.

SAHC will monitor the progress and effectiveness of the Abstinence Education Media Campaign for Indiana RESPECT if funding is available. SAHC will disseminate educational materials and media to agencies and organizations statewide to assure that the public was made aware of the availability of the materials.

Maternal and Children's Special Health Care (MCHSC) will fund school based health centers providing either prenatal care coordination on-site or referral for prenatal care coordination for any pregnant student.

The Free Pregnancy Test Program (FPT) agencies will provide counseling and referrals to health care providers, or provide abstinence or family planning information to sexually active teens with negative pregnancy tests. FPT will be offered at all funded school-based health centers and MCSHC clinics.

To promote 2008 National Day to Prevent Teen Pregnancy. SAHC will ensure that schools

throughout the state are notified of this day and provided with educational materials that address teen pregnancy.

SAHC will collaborate with the ISDH Community Nutrition/Obesity Prevention Division to combat adolescent obesity.

SAHC will continue to collaborate with the Coordinated School Health Program Director on the INSight (Indiana Network of Students Inspiring Good Health Today) Youth Corps program and in planning the Youth Summit.

SAHC will continue to lead the Planning Committee for the Indiana Coalition to Improve Adolescent Health in tasks related to authoring the first state adolescent health plan for Indiana. SAHC will facilitate a coalition meeting in May and at least one more during calendar year 2007.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	33	35	42.7	46	47
Annual Indicator	41.2	47.3	45.1	44.5	44.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	48	49	50	51	51

Notes - 2006
Projected based on last year's information from ISDH Oral Health program.

Notes - 2005
Note: In the past, multiple methods have been used to find this measure, including questions on the BRFSS and in-mouth surveys. Questionnaire surveys from 2000 and 2001 and in-mouth survey from Fall 2000 were conducted. Using these three surveys, an estimate of this measure has been calculated for the 2001 figure. If the questionnaire survey is continued, data from the questionnaire will be used for future reports.

2005: The questionnairre was continued.

Source of Percentage for 2003-2004: ISDH Oral Health program.

Notes - 2004
Note: In the past, multiple methods have been used to find this measure, including questions on the BRFSS and in-mouth surveys. Questionnaire surveys from 2000 and 2001 and in-mouth survey from Fall 2000 were conducted. Using these three surveys, an estimate of this measure

has been calculated for the 2001 figure. If the questionnaire survey is continued, data from the questionnaire will be used for future reports.

2004: The questionnairre was continued.

Source of Percentage for 2003-2004: ISDH Oral Health program.

a. Last Year's Accomplishments
a. Last Year's Accomplishment
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 47% in FY 2006.

Status: Unable to determine

Activities that impacted this performance were:

Due to staff transition no Oral Health Services (OHS) survey of selected third graders occurred.

OHS promoted community-based dental sealant programs, and collaborated with the IU School of Dentistry Community Dentistry's sealant placement program. The ISDH Director of Oral Health Services served on the Board and planning committee of the IU School of Dentistry Mobile Dental Sealant Program.

OHS encouraged dental providers to participate in Hoosier Healthwise and to utilize sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.

OHS dentists coordinated with the Office of Medicaid and Policy Planning (OMPP) on oral health issues.

OHS promoted the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry and to current practitioners throughout the state.

OHS provided oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish.

OHS helped communities gain designation as Dental HPSA and collaborated with ISDH Local Liaison office and Indiana Primary Health Care Association.

OHS collaborated with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

OHS provided sealant educational information to accompany Hoosier Healthwise enrollment information.

ISDH Oral Health Director, MCSHC Medical Director, ISDH Assistant Commissioner for Human Health Services, and representatives from OMPP and Indiana Primary Health Care Association attended the MCHB Oral Health Institute in May 2006. This team conducted a meeting with interested parties and Dr. Bert Edelstien, Dental Services Consultant, to begin Oral Health Strategic Planning in August, 2006.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Oral Health Services (OHS) will survey selected third graders in selected schools, throughout the state.			X	
2. 2. OHS will promote community-based dental sealant programs, and collaborate with the IU School of Dentistry Community Dentistry's sealant placement program.				X
3. 3. OHS will encourage dental providers to participate in Hoosier Healthwise and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.				X
4. 4. OHS dentists will liaise with Office of Medicaid and Policy Planning (OMPP) on oral health issues.				X
5. 5. OHS will promote the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry and to current practitioners throughout the state.				X
6. 6. OHS will continue to provide oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish.				X
7. 7. OHS will help communities gain designation as Dental HPSA and collaborates with ISDH Local Liaison office and Indiana Primary Health Care Association.				X
8. 8. OHS will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).				X
9. 9. OHS will help locate resources for dental case managers in each community who enroll low-income children in Hoosier Healthwise and help parents/guardians to find a local source of dental services.			X	
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 48% in FY 2007.

Activities to impact this performance objective include:

OHS is promoting community-based dental sealant programs, and collaborating with the IU School of Dentistry Community Dentistry's sealant placement program. The ISDH Director of Oral Health Services served on the Board and planning committee of the IU School of Dentistry Mobile Dental Sealant Program.

OHS continues to encourage dental providers to participate in Hoosier Healthwise and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.

The ISDH Director of Oral Health Services is consulting with the Office of Medicaid and Policy Planning (OMPP) on oral health issues.

OHS is promoting the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry and to current practitioners throughout the state.

OHS is currently distributing oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish.

As of June 2007, MCSHC Medical Director is acting as Interim Oral Health Director.

c. Plan for the Coming Year
c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 49% in FY 2008.

Activities to impact this performance objective include:

Oral Health Services (OHS) will survey selected third graders in selected schools, throughout the state. This would update Indiana data.

OHS will promote community-based dental sealant programs, and collaborate with the IU School of Dentistry Community Dentistry's sealant placement program.

OHS will encourage dental providers to participate in Hoosier Healthwise and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.

The ISDH Director of Oral Health Services will liaise with Office of Medicaid and Policy Planning (OMPP) on oral health issues.

OHS will promote the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry and to current practitioners throughout the state.

OHS will continue to provide oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish.

OHS will collaborate with partners such as the IU School of Dentistry, Indiana Dental Association and Indiana Primary Health Care Association to develop an Indiana Oral Health State Plan.

OHS will help communities gain designation as Dental HPSA and collaborate with ISDH Local Liaison office and Indiana Primary Health Care Association.

OHS will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	5.1	4	3	3	3.4
Annual Indicator	3.4	3.2	4.3	3.3	3.3
Numerator	45	43	57	44	

Denominator	1328071	1325771	1330543	1326607	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	3.2	3	2.8	2.6	2.6

Notes - 2006
Projection based on last year's data. 2006 data will not be complete per ISDH ERC until all figures are in to Vital Records and subsequently analyzed. VR does not get them from other states until September, so this will always be a provisional figure.

Notes - 2005
2005 data not yet available. Estimate provided based on trend analysis.
Future objectives have been revised in case estimate is not met.

Notes - 2004
2004 data provided by ERC. As prior year had used an estimate, this is to be considered baseline data.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will be 3.40 in 2006. (Baseline of 3.2 in 2003)

Status: Achieved 3.32%.

Activities that impacted this performance were:

ISDH maintained the draft State Injury Prevention and Control Plan. Of the five injury problems addressed in the Plan, one objective is to reduce the number of teen deaths secondary to motor vehicle crashes.

ISDH implemented a web-based Injury and Violence Prevention Resource Directory, a clearinghouse for information and resources for Indiana: www.in.gov/isdh/programs/injury/index.htm.

ISDH maintained quarterly meetings of the Injury Prevention Advisory Council as a forum to share information about injury prevention programs and activities across the state.

ISDH worked with the Indiana Automotive Safety Program for Children, as well as the Safe Kids Program to promote automotive safety.

ISDH maintained linkage with state and national safety and injury prevention groups.

ISDH funded Riley Hospital for Children to implement the "Checkpoints" teen driving program developed the National Institute of Child Health and Human Development to promote parental involvement in teen driver training.

ISDH shared new developments related to childhood automotive safety with MCSHCS projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. ISDH will continue to use input from the Injury Prevention Advisory Council which meets quarterly.				X
2. 2. ISDH will maintain and update the draft State Injury Prevention and Control Plan.				X
3. 3. ISDH will maintain a web-based Injury and Violence Prevention Resource Center, a clearinghouse for information and resources for Indiana.				X
4. 4. ISDH will work with the Indiana Automotive Safety Program for Children as well as the Safe Kids Program to promote automotive safety.				X
5. 5. ISDH will maintain linkage with state and national safety and injury prevention groups.				X
6. 6. ISDH will share new developments related to childhood automotive safety with MCSHCS projects.				X
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will be 3.2 in 2007. (Baseline of 3.2 in 2003)

Activities to impact this performance objective include:

MCSHC began funding a part-time injury epidemiologist position to support the ISDH Injury Prevention Program.

ISDH maintained the Injury Prevention Advisory Council, which meets quarterly, to share information on injury prevention programs and activities across the state.

ISDH maintains the draft State Injury Prevention and Control Plan, but is unable to finalize the Plan due to lack of resources/personnel. Of the five injury problems addressed in the Plan, one objective is to reduce the number of deaths in teens secondary to motor vehicle crashes.

ISDH is developing a brief data report on Indiana teen motor vehicle crashes to promote this as one objective within the State Adolescent Health Plan that is under development.

ISDH maintained a web-based Injury and Violence Prevention Resource Center as a resource for injury prevention information for Indiana.

ISDH continued to communicate with the Indiana Automotive Safety Program for Children as well as the Safe Kids Program in the promotion of automotive safety.

ISDH maintained linkage with state and national safety and injury prevention groups.

ISDH shared new developments related to childhood automotive safety with MCSHCS projects.

c. Plan for the Coming Year
c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will be 3.0 in 2008. (Baseline of 3.2 in 2003)

Activities to impact this performance objective include:

MCSHC will continue to fund a part-time injury epidemiologist for the ISDH Injury Prevention Program.

ISDH will continue to benefit from the information sharing about statewide programs and activities by maintaining the Injury Prevention Advisory Council, which meets quarterly.

ISDH will update and finalize the draft State Injury Prevention and Control Plan. Of the five injury problems addressed in the Plan, one objective is to reduce the number of deaths in teens secondary to motor vehicle crashes.

ISDH will begin work on an updated version of "Injuries in Indiana" data report, which has one section that focuses on motor vehicle crashes and issues related to adolescent driving.

ISDH will coordinate information on preventing deaths and injuries from teen motor vehicle crashes as one topic area in the current development of an Indiana Adolescent Health Plan.

ISDH will maintain linkage with state and national safety and injury prevention groups and promote automotive safety through local/state programs involved in automotive safety.

ISDH will share new developments related to childhood automotive safety with MCSHCS projects.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					35
Annual Indicator				29.2	30.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	31	33	35	35	35

Notes - 2006
Source of Data: ISDH WIC program.

Notes - 2005
Program director suggested a very aggresive goal of 35%. As this goal was defined as very aggressive, future objectives remain the same until baseline data is established.

a. Last Year's Accomplishments
a. Last Years Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percentage of mothers who breastfeed their infants at hospital discharge will be 67% in FY 2006. (This was changed to: The percentage of mothers who breastfeed their infants at 6 months of age will be 35%.)

Status: Baseline Figure = 30.2%
(Note: roughly half of the women who breastfeed at birth still breastfeed at 6 months)

Activities that impacted this performance were:

The State Breastfeeding Strategic Plan "Born to Be Breastfed- A Call to Action" was distributed statewide.

From 04/01/06 to 9/30/06 there were 40,000 visits to the IPN web page and the Breastfeeding Call to Action document was downloaded more than 2,700 times.

Breastfeeding information and the State Breastfeeding Plan was shared at the 2nd quarterly State Perinatal Advisory Board Meetings and was the topic of the Spring Perinatal Perspectives professional newsletter.

WIC trained professionals at nine (9) hospitals on breastfeeding management in the first 2-3 days of life.

The office of Community Nutrition Obesity Prevention (CNOP), MCSHC, and the Indiana Perinatal Network's (IPN) initiated development of a statewide breastfeeding media campaign. The campaign will be implemented in summer of 2007.

An Indiana breastfeeding logo was completed in 2006.
http://www.in.gov/isdh/programs/cnop/pdfs/breastfeeding_logo.pdf

MCSHC funded prenatal clinics and prenatal care coordinators encouraged breastfeeding to all patients and improved breastfeeding rates among their clientele.

Three regional trainings of statewide prenatal care coordinators in May 2006 included a session on breastfeeding and the Call to Action.

Members of IPN and WIC attended the January 2006 CDC conference by the United States Breastfeeding Committee that charged states with developing state coalitions to address breastfeeding at the local level.

Indiana organized 10 local breastfeeding coalitions and a state central coalition. Each area identified one or two lead persons and a toolkit was developed to assist with initial local

organization.

The first annual State Coalition Meeting, modeled after the National Conference for was held on September 7, 2006 where 100 persons were trained on coalition building. Each region was provided with up to $400 to organize locally.

MCSHC recognized a business in each coalition region with an award in August or September 2006.

A breastfeeding website was developed by CNOP can be found at:
http://www.state.in.us/isdh/programs/breastfeeding/index.htm

Indiana Family Helpline staff was educated about breastfeeding in December 2005 and procedures for responding to any breastfeeding request were formalized to equip the helpline to answer questions about Indiana's breastfeeding law about public breastfeeding enacted in 2004.

The CNOP program co-sponsored the 40-45 hour International Board of Lactation Examiners requirement training to 150 health professionals to enable them to take the IBCLC exam.

The Indiana Mother's Milk Bank was opened with support from the ISDH Commissioner, MCSHC, CNOP, and IPN.

WIC, ISDH, and IPN collaborated with the Indiana Mother's Milk Bank to create a Lactation Station at the Indiana State Fair that was well received and highlighted in the local media.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. MCSHC will support an annual meeting of the State Breastfeeding Coalitions.				X
2. 2. There will be a 40-45 hour training provided to health professionals that meets the International Board of Lactation Examiners requirement for the exam to become an International Board Certified Lactation Consultant.				X
3. 3. The Indiana Perinatal Network Breastfeeding Task Force will provide leadership to the State Breastfeeding Coalition.				X
4. 4. The Community Nutrition program will maintain the Indiana State Breastfeeding website for the public and providers.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
b. Current Activities
b. FY 2007 Current Activities
FY 2007 Performance Objective: The percentage of mothers who breastfeed their infants at 6 months of age will be 31% in FY 2007.

Activities include:

A State Breastfeeding Steering Committee will be formed from chairs of the Indiana Perinatal Breastfeeding Committee, State AAP breastfeeding committee, LaLeche League, Indiana Milk Bank, WIC, ISHD Community Nutrition Obesity Program, MCSHC, Office of Women's Health to review the state action plan and develop state priorities. Local coalitions and existing breastfeeding committees will implement recommendations of the Steering Committee. The Steering Committee will develop a method for obtaining quality data to fully assess the status of breastfeeding in Indiana at time of discharge, 3 and 6 months postpartum.

There will be an annual meeting of the State Breastfeeding Coalitions by September 30, 2007. Two new county coalitions will be formed.

The International Board of Lactation Examiners requirement for 40-45 hours of training prior to applying to sit for the exam to become an International Board Certified Lactation Consultant (IBCLC) will be provided to health professionals.

The Community Nutrition program will maintain and update the Indiana State Breastfeeding website for the public and providers. The website will also include an interactive map for local coalitions to post information.

The State Breastfeeding Media Campaign materials will be completed by September 30, 2007.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The percentage of mothers who breastfeed their infants at 6 months of age will be 33% in FY 2008.

Activities to impact this performance objective include:

The Breastfeeding Steering Committee will be maintained and a State progress report will be published by September 30, 2008.

The Steering committee will apply for funding to create a Breastfeeding Center.

The Steering committee will assist the Office of Community Nutrition Obesity Prevention (CNOP) in writing the State CDC grant.

CNOP will continue to maintain and update the breastfeeding website for consumers and professionals.

State Breastfeeding media materials will be shared with county coalitions.

Grandmother's teas to promote African American breastfeeding will be sponsored by each county breastfeeding coalition.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	99	99	99	98.4	98.6
Annual Indicator	98.0	99.7	97.9	99.6	99.6
Numerator	85374	84490	86077	87371	
Denominator	87116	84744	87927	87685	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	99.6	99.7	99.7	99.7	99.8

Notes - 2006
Projection used, as ISDH ERC is in process of verifying questionable immunization data.

Notes - 2005
Final information received from ISDH Newborn Screening Program; figures updated.

Notes - 2004
Source of percentage: Newborn Screening program

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
Performance Objective: Maintain or improve universal newborn hearing screens at 98.6% in FY 2006.

Status: In CY 2006, 98.6% of infants born in Indiana received a newborn hearing screen.

Activities that impacted this performance were:

Quality Assurance protocols were developed to monitor the accuracy of Monthly Summary Report (MSR) and Diagnostic Audiology Evaluation (DAE) form data entry.

IU lab's new data management system, Specimen Gate, incorporating UNHS data from blood spot cards, became functional in October, 2005. This database is now being used to assist with follow-up for babies who may not have been screened for hearing loss, may not have passed UNHS, and those who may have risk factors associated with delayed onset of hearing loss.

Early Hearing Detection and Intervention (EHDI) continued to develop the web-based Universal Newborn Hearing Screening (UNHS) / EHDI Datamart which will replace the paper Monthly Summary Report (MSR) and Diagnostic Audiology ODS. Internal testing of the system began August 2006 and is continuing.

EHDI developed procedures to track and ensure that children with hearing loss are enrolled in appropriate early intervention services by six months of age and built the procedure into the new web-based EHDI Data Mart.

State audiologists worked with First Steps to develop signed reciprocal releases of information that the First Step Intake and Service Coordinators can collect. Until this is widely collected, monthly data from First Steps will not be obtained to fulfill the CDC-EHDI data recommendations,

as Family Education Rights and Privacy Act (FERPA) prevent sharing of child specific information.

EHDI partnered with First Steps (FS) and other stakeholders to improve the referral and evaluation process to increase the number of children receiving audiology services before three months of age. ISDH shared the Diagnostic Level 1 Centers lists with FS and implemented use of the reciprocal release to allow FS to be able to share results with ISDH.

The Early Hearing Detection and Intervention (EHDI) Staff including the EHDI Regional Audiology Consultants provided education and technical assistance to hospitals and birthing facilities. A total of 47 hospital visit/trainings and 4 Public Health Nurse trainings were held.

EHDI provided educational presentations to students, physicians, and families about UNHS/EHDI procedures, goals and objectives. There were 2 presentations for Primary Care Physicians (PCPs). ISDH also sponsored an EHDI Conference for audiologists and physicians for reducing the number of babies lost to follow-up. The annual Family Conference for Professionals and Families was held in June 2006.

EHDI, Outreach Services for Deaf and Hard of Hearing Children and First Steps have trained an additional 19 people to become Parent Advisors using the SKI*HI curriculum to assist with building capacity throughout the state with individuals who are skilled at working with families of deaf or hard of hearing children. In addition, EHDI and Outreach presented 4 training sessions for the Early Intervention SPOEs about the SKI*HI program.

EHDI provided education to hospitals, public health nurses, audiologists, early interventionists, and others about the Medical Home concept and distributed materials statewide. The medical home concept is included in all presentations that are given. This was done 6 times this year, in conjunction with the Hospital/PHN trainings.

State Audiology Coordinator collaborated with Delta Zeta Sorority to ensure continued dissemination of Sound Beginnings materials to physicians, birthing centers, WIC clinics, and other appropriate entities around the state.

EHDI submitted a grant proposal and received funding from Health Resources and Services Administration (HRSA) to support UNHS and EHDI Program development.

State Audiology Coordinator partnered with the American Academy of Pediatricians (AAP) to appoint a new EHDI Chapter Champion (Dr. Betsy Neahring) for the state of Indiana.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. Maternal and Children's Special Health Care (MCSHC) will develop and provide education regarding UNHS to Amish communities in Indiana.			X	
2. 2. MCSHC will establish a reporting mechanism with ISDH Vital Records to be notified of home births.				X
3. 3. MCSHC will establish a reporting mechanism with ISDH Vital Records to be notified of home births.				X
4. 4. EHDI Program will partner with Department of Education and Outreach Services for Deaf and Hard of Hearing Children to				X

bring the Early Childhood Outreach (ECHO) program to Indiana.				
5. 5. EHDI will provide education presentations to hospitals, Public Health Nurses (PHN) students, physicians, audiologists, early interventionists, and other interested parties regarding EHDI goals, objectives and procedures.			X	
6. 6. EHDI will provide education presentations to hospitals, Public Health Nurses (PHN) students, physicians, audiologists, early interventionists, and other interested parties regarding EHDI goals, objectives and procedures.			X	
7. 7. EHDI to educate physicians, audiologists, and other interested parties about the Medical Home concept and the importance of every child having a Medical Home.				X
8. 8. EHDI will provide a packet of EHDI specific information when a child is diagnosed with hearing loss to the identified Medical Home.			X	
9. 9. Newborn Screening Program will implement new, more efficient, effective methods to deliver hospital and PHN trainings.				X
10. 10. EHDI will improve the number and percentage of babies born at home who receive UNHS.			X	

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: Improve universal newborn hearing screens to 98.7% in FY 2007.

Activities to impact this performance objective include:

EHDI received contact information for all licensed Ear, Nose and Throat physicians in the state and sent out letters educating them regarding their responsibility to report any child with hearing loss to the Indiana Birth Defects and Problems Registry (IBDPR), via the IBDPR Reporting Form.

Maternal and Children's Special Health Care (MCSHC) will develop and provide education regarding Universal Newborn Hearing Screening/Early Hearing Detection and Intervention (UNHS/EHDI) to the Amish communities in northeastern and southwestern parts of Indiana.

EHDI will develop a method to identify babies born at home or by midwives who did not receive UNHS and begin contacting those families to educate them about the importance of newborn hearing screening. The State Audiology Coordinator will continue to give presentations to the Indiana Mid-wives Association.

EHDI hired a Parent Consultant to assist with follow-up for babies who may not have received UNHS, who may not have passed UNHS, or who may have risk factors associated with delayed onset of hearing loss.

EHDI will continue to partner with the Indiana Chapter of Hands & Voices to modify the Indiana Family Resource Guide.

c. Plan for the Coming Year

c. Plan for the Coming Year

c. Planned Activities for FY 2008

FY 2008 Performance Objective: Improve universal newborn hearing screens to 98.8% in FY 2008.

Activities to impact this performance objective include:

EHDI (State Audiology Coordinator, Parent Consultant, and Regional Consultants) will continue to train hospitals in the new datamart reporting system (EARS).

MCSHC will establish a reporting mechanism with ISDH Vital Records to be notified of home births.

A Memorandum of Understanding (MOU) will be developed to be used with Regional Audiology Diagnostic Centers to improve the quality of pediatric diagnostic testing in the state, to improve the number of children diagnosed with hearing loss that are reported to the EHDI Program, and to reduce the number of infants lost to follow-up.

EHDI will continue to provide education presentations to hospitals, Public Health Nurses (PHN), students, physicians, audiologists, early interventionists, and other interested parties regarding EHDI goals, objectives and procedures.

Continued training for pediatric audiologists and equipment requirements for Level 1 status will occur.

EHDI will continue to mail EHDI materials to all Public Health Departments to improve Public Health Nurse (PHN) understanding of goals, objectives, and follow-up procedures for the EHDI program. Due to staff turnover, this was not able to be completed in 2006.

EHDI will identify communities with large Amish populations and begin assisting these communities in having UNHS screenings completed.

EHDI will continue to dialogue with the Midwifery facilities and provide loaner equipment to assist these facilities to begin UNHS programs.

EHDI staff will continue the efforts to educate physicians regarding follow-up from screening and send physician packets to any primary care physician who has a child with documented hearing loss in his/her care.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	10.5	10	6	12	8.7
Annual Indicator	9.0	12.9	8.9	9.5	10.0
Numerator	142000	206111	144000	161260	158000
Denominator	1574390	1603970	1617977	1689985	1577629
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**

Annual Performance Objective	9.5	9.1	8.7	8.3	7.9

Notes - 2006
Provisional estimate from Robert Wood Johnson foundation figures and US Census Bureau figures.

Notes - 2005
Additional Note: Final figures used from Robert Wood Johnson Foundation for FY2005.

For FY2004, the data source is Annie E Casey foundation "Kids Count 2005" as the variability is no longer as large as the three year average previously used.

Because of this, the objective for 2005 should have been changed to maintain at 8.9. However, in 2004 we were unable to determine if the 2003 figure or the 2004 figure would be the correct one to use as a baseline. This has now been determined, so in future the 2005 objective should read 8.9; however the computer application does not allow us to change objective for current or past years to correct provisional data.

Notes - 2004
For FY2004 and forward, the data source is Annie E Casey foundation "Kids Count 2005" as the variability is no longer as large as the three year average previously used.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY2006 accomplishments
Performance Objective: To decrease the percent of children without insurance to 8.7% in FY 2006.

Status: Not Achieved (9.1%)

Activities that impacted this performance were:

The MCHB funded project, Indiana Early Childhood Comprehensive System Program continues including strategies to increase the percentage of children on childcare voucher programs who have a medical home.

The MCSHC Early Childhood Comprehensive Services now known as Sunny Start: Healthy Bodies, Healthy Minds now provides service information to families via a website.

The Sunny Start Program has expanded the website to provide families and early childhood providers with resource and support information-(http://earlychildhoodmeetingplace.indiana.edu/index.htm). Each Indiana county is represented on the site with pertinent information regarding local, county, and state services including topics like Community Resources, Child Care and Education, Health and Safety, and Parenting and Families.

The Sunny Start Program adopted the Utah Clicks universal application software to be used by the Indiana WINS project which began pilot testing in Spring 2007. Indiana WINS, our electronic universal application for public programs, will also check to see if children have a medical home.

Sunny Start is working with the child care voucher program to ensure that when families apply for child care subsidies, they are asked if their child has a medical home.

MCSHC grantees serve as enrollment sites for Hoosier Healthwise or they refer clients to local Hoosier Healthwise enrollment sites.

MCSHC requires all grantees providing primary care to children to be Medicaid providers.

MCSHC Family Care Coordination grantees facilitate children into Hoosier Healthwise.

All callers to the Indiana Family Helpline (IFHL) were screened for income and whether they are currently on Medicaid. In 2005 45 were referred to Medicaid.

MCSHC Director serves on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and is on the Hospital & Health Center subcommittee.

MCSHC staff participate in the Department of Family Resources Partnership subcommittee.

CSHCS program provided for children enrolled in the program last payer reimbursement for primary care and specialty care and hospitalization for services related to the diagnosis that made them eligible for the program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. The MCHB funded project, the Indiana Early Childhood Comprehensive System Program will develop strategies to increase the percentage of children on child care voucher programs who have health insurance.				X
2. 2. The MCSHC Sunny Start:Healthy Bodies, Healthy Minds program will provide service information to families via a website.			X	
3. 3. MCSHC grantees will serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.		X		
4. 4. The Indiana Family Helpline will provide referrals and screens clients for Hoosier Healthwise eligibility.		X		
5. 5. MCSHC requires all grantees providing primary care to children to be Medicaid providers.				X
6. 6. MCSHC Family Care Coordination grantees will facilitate children into Hoosier Healthwise.		X		
7. 7. MCSHC will be represented on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.				X
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY2007 Current activities

Performance Objective: To decrease the percent of children without insurance to 9.5% in FY2007.

Activities to impact this performance objective include:

The MCHB funded project, the Indiana Early Childhood Comprehensive System (ECCS) Program continues to include strategies to increase the percentage of children on child care voucher programs who have health insurance.

The MCSHC Sunny Start: Healthy Bodies, Healthy Minds program continues to provide service information to families via a website.

MCSHC grantees serve as enrollment sites for Hoosier Healthwise or refer clients to local Hoosier Healthwise enrollment sites.

The Indiana Family Helpline provides referrals and screens clients for Hoosier Healthwise eligibility.

MCSHC requires all grantees providing primary care to children to be Medicaid providers.

MCSHC Family Care Coordination grantees facilitate children into Hoosier Healthwise.

The MCSHC Director serves on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.

CSHCS program will continue to provide for children enrolled in the program last payer reimbursement for primary care and specialty care and hospitalization for services related to the diagnosis that made them eligible for the program.

The 2007 Indiana General Assembly extended Medicaid coverage for children whose family income is up to 300 % of the federal poverty level

c. Plan for the Coming Year
c. Plan for the Coming Year
c. Planned Activities for 2008
Performance Objective: To decrease the percent of children without insurance to 9.1% in FY2008.

Activities to impact this performance objective include:

The MCHB funded project, the Indiana Early Childhood Comprehensive System Program will continue to include strategies to increase the percentage of children on child care voucher programs who have health insurance.

The MCSHC Sunny Start - Healthy Bodies, Healthy Minds program will continue to provide service information to families via a website. The website will be expanded to include more information.

MCSHC grantees will continue to serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.

The Indiana Family Helpline will continue to provide referrals and screens clients for Hoosier Healthwise eligibility.

MCSHC will continue to require all grantees providing primary care to children to be Medicaid providers.

MCSHC Family Care Coordination grantees will continue to facilitate children into Hoosier Healthwise. Emphasis on doing so will be increased.

The MCSHC Director will continue to serve on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.

MCSHC staff will continue to participate in the Department of Family Resources Partnership subcommittee.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					23
Annual Indicator				23.0	49.2
Numerator				18232	
Denominator				79406	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	49	47	45	43	41

Notes - 2006
WIC information provided to us a correction for CY2005 for baseline figures. However, the TVIS application would not let us change CY2005's figures; here are the actuals:

CY2005 Numerator: 25320
CY2005 Denominator: 51472

Which equals 49.2%.

The previous figure of 23% did not include >95% numbers.

CY2006 figure estimated based on CY2005 actuals.

Source of data: ISDH WIC Program

Notes - 2005
Figures provided by WIC. These are CY 2005 figures. Adding risk factors 113 & 114 together gives the number of children at or above the 85th percentile.

Baseline has been established, as we have from WIC figures for CY 2003 and 2004 as follows:

CY 2003 - Total Children ages 2 to 5 receiving WIC services: 79484
CY 2003 - Total Children with risk factor 113: 7658
CY 2003 - Total Children with risk factor 114: 9635

CY 2004 - Total Children ages 2 to 5 receiving WIC services: 80374
CY 2004 - Total Children with risk factor 113: 8197
CY 2004 - Total Children with risk factor 114: 10171

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile will be 23.

Status: Not Achieved (49%)

Note: This is a new Performance Measure for FY2007. No specific activities were listed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. WIC health professional will screen all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%).			X	
2. 2. WIC clinics will increase the number of children who were assigned Risk Factor 113 at the previous certification who do not have that risk factor at the time of recertification by 1% and Risk Factor 114 by 2%.		X		
3. 3. WIC clinics will increase the number of children who were assigned Risk Factor 113 at the previous certification who do not have that risk factor at the time of recertification by 1% and Risk Factor 114 by 2%.			X	
4. 4. Counseling of families of WIC eligible children will include as appropriate, physical activity ideas, reduced sedentary activities, and healthy eating.			X	
5. 5. WIC and MCH projects will continue to display posters/bulletin boards on physical activity, feeding relationship and foods choices and their importance.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
b. Current Activities
b. FY 2007 Current activities.
FY 2007 Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile will be 49%.

Activities to impact this performance objective include:

WIC health professionals will screen all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%).

WIC clinics objective is to increase the number of children who were assigned Risk Factor 113 at the previous certification who do not have that risk factor at the time of recertification by 1% and Risk Factor 114 by 2%.

WIC health professionals assess WIC eligible children's' diets for eating and feeding practices that would affect growth patterns.

WIC provides or refers families of WIC eligible children for counseling that includes as appropriate, physical activity ideas, reduced sedentary activities, and healthy eating.

WIC and MCH projects continues to display posters/bulletin boards on physical activity, feeding relationship and foods choices and their importance.

MCSHC will provide INShape Indiana magnets and bookmarks to public health clinics including WIC.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile will be 47%.

Activities to impact this performance objective include:

WIC health professionals will screen all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%).

WIC health professionals will assess WIC eligible children's' diets for eating and feeding practices that would affect growth patterns.

When appropriate WIC will provide counseling to families of WIC eligible children that will include, physical activity ideas, reduced sedentary activities, and healthy eating information.

WIC will display posters/bulletin boards on physical activity, feeding relationship and foods choices and their importance.

WIC will provide educational materials (books, handouts, videos) on healthy eating and physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					16.1
Annual Indicator				16.2	15.9
Numerator					15589
Denominator					97788
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	15.8	15.7	15.6	15.5	15.5

Notes - 2006
Information estimated based on number of women who reported smoking on birth certificates. All of those who reported smoking on the birth certificate were definitely smoking during the final trimester. This is probably close to the actual percentage, as it only omits women who smoked through the end of their second trimester but quit prior to delivery.

Source of data: ISDH Vital Records (Birth Certificate Information)

Notes - 2005
Baseline information for 2004 is 15954 numerator, 97818 denominator with an indicator of 16.3.

Source of 2005 indicator: ISDH Epidemiology Resource Center.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percent of very low birthweight infant among all live births will be maintained at 1.3% in FY 2006.

Status: Objective Met

(In 2007 this PM changed to Percentage of Women who smoke in the last three months of pregnancy.)

Activities that impacted this performance were:

MCSHC funded direct care services to provide prenatal care to high-risk low-income pregnant women.

Results from Marion County Perinatal Periods of Risk (PPOR) were shared through Indiana Perinatal Network (IPN) Newsletter. MCSHC and IPN provided technical assistance to the 6 targeted counties to begin local PPOR but counties do not have the resources to do PPOR at this time.

Prenatal projects examined all cases of infant mortality and low birthweight occurring in their clinics to find commonalities and causes to develop strategies to improve clinic outcomes. Preliminary analysis shows that 54% of the pregnancies were unintended, 51% of the mothers smoked during pregnancy, 26% of the mothers had inadequate wt gain, 13% of the mothers experienced an infection and 13% of the mothers used illegal substances.

Funded Fetal Infant Mortality Reviews (FIMR) were conducted in Marion, Lake, St. Joseph, and Vanderburgh Counties. A preliminary state FIMR report will be published in 2007.

IPN hosted the State Conference on Perinatal Bereavement.

MCSHC/IPN facilitated three regional Perinatal Provider Education Conferences on latest research and recommendations in Vigo, Vanderburgh and Allen Counties.

MCSHC updated Baby First media campaign, consumer video and educational handouts to correspond to new best practices.

MCSHC convened issues subcommittees of the State Perinatal Advisory Board on unintended pregnancy/birth spacing, and prenatal mental health/substance abuse.

The Community Council on Infant Health and Survival convened subcommittees on accurate death certificate information training, education for providers on safe sleep and planned for a conference on best practices for safe sleep and other infant death prevention based on early FIMR reports.

The Medicaid Family Planning Waiver was still being completed with input from MCSHC and IPN.

The IPN Doula pilot program was implemented in Marion County and is being evaluated.

MCSHC maintains an up-to-data database of all infant deaths.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. The ISDH Prenatal Substance Use Prevention Program (PSUPP) will identify high risk, chemically dependent pregnant women.			X	
2. 2. Indiana birth certificates will have information on women who smoke in the last three months of pregnancy for calendar year 2007. Data will be available in fiscal year 2008.			X	
3. 3. MCSHC will provide training on Federal Resource Enabling Data system (FRED) to all funded prenatal projects on correct data entry on smoking usage per trimester.				X
4. 4. PSUPP/MCSHC will collaborate with Smoke Free Indiana to reach a broader audience and have greater impact on smoking cessation with pregnant women.				X
5. 5. MCSHC consultant will continue to provide brochures on “You and Me Smoke-Free” and the “ASK” Protocol as well as offer downloading from MCSHC website.			X	
6. 6. PSUPP will educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.			X	
7. 7. All MCSHC funded projects will be instructed to refer pregnant women to the Quit Now program available by telephone at 1-800-QUIT-NOW.			X	
8. 8. MCSHC will provide a link to the web based training “Smoking Cessation for Pregnancy and Beyond—Learn Proven Strategies to Help Your Patients Quit” for providers.				X
9. 9. MCSHC will analyze the rate of smoking in the third trimester on a quarterly basis to determine further training needs.				X
10.				

b. Current Activities

b. Current Activities

b. Current Activities for FY 2007

FY 2007 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be 15.8 in FY 2007.

Activities to impact this performance objective include:

MCSHC has contracted to have in-depth analysis of maternal smoking and birth outcomes data.

MCSHC defines common measures and processes to be applied across all funded projects to capture data identifying pregnant smokers at the time they enter prenatal care and at each subsequent trimester of pregnancy to establish changes in smoking status during the pregnancy.

Indiana birth certificates will have information on women who smoke in the last three months of pregnancy for calendar year 2007. Data will be available in fiscal year 2008.

MCSHC will provide training on Federal Resource Enabling Data system (FRED) to all funded prenatal projects on correct data entry on smoking usage per trimester.

PSUPP/MCSHC is collaborating with Smoke Free Indiana to reach a broader audience and have greater impact on smoking cessation with pregnant women. Smoking cessation coalitions formed by the Indiana Tobacco Prevention Cessation (ITPC) program in all 92 counties will be brought in for training by Smoke Free Indiana to return to their counties and train health professionals, social service agencies, school personnel and other community persons working with pregnant women on the effects of smoking during pregnacy on the mother and fetus.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be 15.7 in FY 2008.

Activities to impact this performance objective include:

ISDH will facilitate a legislative commission on prenatal smoking, alcohol, and drug use to develop a strategic plan.

The ISDH Prenatal Substance Use Prevention Program (PSUPP) will identify high risk, chemically dependent pregnant women and provide counseling and intervention.

PSUPP/MCSHC will collaborate with Smoke Free Indiana to reach a broader audience and have greater impact on smoking cessation with pregnant women. Smoking cessation coalitions formed by the Indiana Tobacco Prevention Cessation (ITPC) program in all 92 counties will be brought in for training by Smoke Free Indiana to return to their counties and train health professionals, social service agencies, school personnel and other community persons working with pregnant women on the effects of smoking during pregnancy on the mother and fetus and the Indiana Tobacco Quit Line.

PSUPP will educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.

MCSHC will continue to collaborate with the Indiana Lung Association in training for smoking cessation cessation in 5 focus counties for prenatal clients.

All MCSHC funded projects will be instructed to refer pregnant women to the Quit Now program available by telephone at 1-800-QUIT-NOW. MCSHC consultant will review referral reports from funded projects and provide consultation and technical assistance to projects to increase referrals to the Quit Line.

MCSHC will analyze the rate of smoking in the third trimester on a quarterly basis to determine further training needs.

PSUPP will distribute informational items about the impact of substance use among pregnant women to the public.

PSUPP clinics (3) will provide support groups for women in substance use cessation.

MCSHC staff will work with Hoosier Healthwise & Contracted MCO's health care providers and outreach workers on smoking cessation.

MCSHC will complete the on-site training of OB providers and offices staff in Crawford, Clark, Scott, Jefferson, and Perry Counties.

MCSHC will conduct 3 month post assessment of office practices and continue on-site training as needed.

MCSHC will replicate prenatal office trainings in 5 more counties with significant prenatal smoking rates.

MCSHC will work with Indiana ACOG to disseminate information on prenatal smoking cessation.

Baby First Packets will be sent to Prenatal IFHL callers that includes information on smoking cessation.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	6.9	8	8	8	8
Annual Indicator	9.1	6.6	8.1	6.9	6.9
Numerator	40	29	36	31	
Denominator	440239	442311	445489	450445	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6.9	6.9	6.8	6.7	6.6

Notes - 2006
Estimate provided based on previous year's figures which are now final. Despite this measure fluctuating considerably, it is hoped we can maintain at CY2005's level of 6.9.

TVIS application did not allow changing objective for 2006; projected objective would have been changed to 6.9.

Notes - 2005
All data are for the calendar year and not the fiscal year.

Source of Data: ISDH ERC.

Notes - 2004
All data are for the calendar year and not the fiscal year.

Source of Data: ISDH ERC.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The rate of suicide deaths among youths aged 15-19 will be maintained at 8.0 in FY 2006. (Baseline rates of 9.1 in 2002 and 6.6 in 2003).

Status: Achieved 7.6%

Activities that impacted this performance were:

MCSHC funded the part time Administrative Coordinator for the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 11 regional coalitions.

1. ISDH collaborated with the Indiana Suicide Prevention Coalition to implement the State Suicide Prevention Plan. Coalition accomplishments related to the Plan include:
- o Distribution of the "Youth Suicide Prevention School-Based Guide" on CD-ROM to 550 public and private Indiana Schools
- o Creation of a suicide prevention awareness brochure and a statewide listserv
- o Presentations at numerous conferences and meetings
- o A media campaign to promote National Suicide Prevention Week, including an ISDH press release and six suicide prevention walks across the state
- o Organization of a new (12th) suicide prevention regional council in Northwest Indiana
- o A summary of evidence-based youth suicide prevention programs and screening tools
- o Reviewed data obtained from the statewide assessment of youth suicide resources and presented the preliminary findings at the September 2006 Coalition meeting
- o Identification of suicide prevention programs for employee assistance programs (EAPs), with information provided to the five largest EAPs in the state.

2.The Coalition also:
- o Implementation of panel discussions on suicide prevention in several Indianapolis churches.
- o Participation in a site visit of the Columbia Teen Screen tool in an Indiana high school.
- o Development of recommendations on youth suicide prevention for the Indiana Children's Social, Emotional, and Behavioral Health Plan.
- o Provided technical assistance to a wide variety of community organizations, educational institutions, and state-level agencies.

ISDH maintained a draft of a State Injury Prevention and Control Plan, which has not yet been finalized. Of the five injury problems addressed in the Plan, one objective is to reduce the number of teen suicide deaths.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. MCSHC will support the Indiana Suicide Prevention Coalition.				X
2. 2. ISDH will collaborate with the Indiana Suicide Prevention Coalition to implement the State Suicide Prevention Plan.				X
3. 3. The Coalition will hold panel discussions on suicide prevention in Indianapolis churches.			X	
4. 4. The Coalition will establish regional suicide prevention councils in underserved areas of Indiana.				X
5. 5. The Coalition will promote gatekeeper training programs for schools.				X
6. 6. The Coalition will provide technical assistance to a wide variety of community organizations, educational institutions, and state-level agencies.				X
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 6.9 in FY 2007. (Baseline rates of 9.1 in 2002 and 6.6 in 2003).

Activities to impact this performance objective include:

MCSHC continues to fund the part time Administrative Coordinator for the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 12 regional coalitions.

ISDH was unable to finalize the draft of the State Injury Prevention and Control Plan (which includes youth suicide as one of five objectives) due to lack of personnel in the ISDH Injury Prevention Program.

ISDH began work on a new version of the well-received data report on Suicide in Indiana.

1. ISDH continued to collaborate with the Indiana Suicide Prevention Coalition to implement the State Suicide
Prevention Plan. Coalition accomplishments include:
o Mass distribution of a suicide prevention awareness brochure and continued maintenance of a statewide
listserv.
o Presentations at numerous conferences and meetings, along with distribution of pertinent information
about suicide prevention.
o Continued promotion of gatekeeper training programs for schools.

o Collaboration with a Northeast Indiana Area Health Education Center (AHEC) to incorporate suicide
prevention awareness into youth activities.

o Review, updating and editing of the Student Suicide Manual for schools.

c. Plan for the Coming Year
c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 6.9 in FY 2007.

Activities to impact this performance objective include:

MCSHC will continue to fund the part time Administrative Coordinator for the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 12 regional Coalitions.

ISDH will continue to work on finalization of the draft of the State Injury Prevention and Control Plan, which includes youth suicide as one of five objectives.

ISDH will complete an updated data report on Suicide in Indiana, to be published electronically through the ISDH Injury Prevention Program website.

1. ISDH will continue to collaborate with the Indiana Suicide Prevention Coalition to implement the State
Suicide Prevention Plan. Planned Coalition activities supporting goals in the Plan include:
o Coordination of at least one educational offering for schools on managing loss due to suicide of a student.
o Scheduling regional workshops to implement an updated version of the Indiana Department of Education
Manual on Suicide in Students.
o Hosting two gatekeeper instructor trainings to provide this expertise to all area of the state as well as
promoting gatekeeper training for schools.
o Identification of information and programs that address the needs of the metropolitan area telephone
survey on suicide awareness and attitudes to be conducted in June 2007.
o Scheduling a meeting/training for suicide survivor groups around the state to further develop support skills.
o Providing suicide-related resources to Indiana hospital emergency departments.
o Distributing media guidelines to newspapers to encourage sensitive reporting of suicides.

The Coalition will maintain a listserv and continue efforts to establish regional suicide prevention councils in underserved areas of Indiana.

The Coalition will continue to provide technical assistance to a wide variety of community organizations, educational institutions, and state-level agencies.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	57.5	58	58	77	80
Annual Indicator	56.4	76.4	78.5	77.4	77.4
Numerator	664	941	1002	947	
Denominator	1177	1231	1277	1224	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	81	82	83	84	84

Notes - 2006
All data are for the calendar year and not the fiscal year.

Estimates provided based on CY2005 figures which are now final. CY2006 data is not yet available.

Notes - 2005
All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center.

The numerator is total number of occurrent births of Very Low Birth Weight at hospitals who have self-declared their status as a level 3 hospital. Although Indiana does not have a formal perinatal system in place, the Indiana Perinatal Network conducted a new survey in FY 2003 which requested that hospitals identify their level according to established standards. The denominator is the total occurent births of Very Low Birth Weight.

Notes - 2004
All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center.

The numerator is total number of occurrent births of Very Low Birth Weight at hospitals who have self-declared their status as a level 3 hospital. Although Indiana does not have a formal perinatal system in place, the Indiana Perinatal Network conducted a new survey in FY 2003 which requested that hospitals identify their level according to established standards. The denominator is the total occurent births of Very Low Birth Weight.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be maintained at 80% in CY 2006.

Status: Not Met (77.4%)

Activities that impacted this performance were:

ISDH reviewed Fetal Infant Mortality Review (FIMR) data for appropriate deliveries and transport of high-risk deliveries and neonates. MCSHC met with all FIMR teams to gather data and provide technical assistance updates. Preliminary data from the FIMR groups show there are still some problems with women walking into an out-of-network hospital in labor, unfortunately these women are most likely to be higher risk women. 2003 birth data shows that 78% of all very low birthweight infants were born at appropriate hospitals.

ISDH provided trainings on appropriate transfer of high-risk deliveries and neonates through IPN. The Prenatal Continuing Education Program (PCEP) was provided through St. Mary's Hospital for Women and Children, Evansville as the lead hospital, with Good Samaritan Hospital in Vincennes, Gibson General Hospital in Princeton and Memorial Hospital and Health Care Center in Jasper also participating.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. MCSHC will update the Levels of Care document through review of hospital services.				X
2. 2. MCSHC will provide technical assistance to hospitals wanting to improve their level.				X
3. 3. Birth data by hospital will reviewed by a MCH epidemiologist and consultant for appropriate deliveries and transport of high-risk deliveries and neonates. MCSHC will notify counties of any problems.				X
4. 4. Results of the birth data review will be posted on the IPN website				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 81% in CY 2007.

Activities to impact this performance objective include:

MCSHC will update the Hospital Levels of Care document through review of hospital services in 2007.

The Indiana Prenatal Care Guidelines will be updated by September 30, 2007 and will include when to transport.

MCSHC is providing technical assistance to hospitals wanting to improve their level.

Birth data by hospital is being reviewed by a MCH epidemiologist and consultant for appropriate deliveries and transport of high-risk deliveries and neonates. MCSHC will notify counties of any

problems.

Results of the birth data review will be posted on the IPN website in 2007.

MCSHC is participating on the Office of Medicaid Policy and Planning Quality Strategy Prenatal Workgroup. The CMS 7 point initiative to improve neonatal outcomes will be incorporated into developed performance measures for MCOs.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 82% in CY 2007.

Activities to impact this performance objective include:

A PCEP (Prenatal Continuing Education Program) training for coordinators (Train-the Trainers) will be hosted by St. Vincent hospital in Marion County. All tertiary hospitals will be trained to teach PCEP to surrounding feeder hospitals. It is hoped this will lead to a natural perinatal system of care and will improve appropriate transfer rates of high risk mothers.

A working group of state maternal-fetal specialists will be formed to develop a performance measures report that will be shared with all hospitals.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	80	80.2	80.4	81.1	81
Annual Indicator	80.5	80.6	78.5	78.2	78.2
Numerator	68330	69605	69054	68723	
Denominator	84839	86382	87961	87864	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	78.5	79	79.5	80	80.5

Notes - 2006
2006 data not yet available. Estimate provided based on last years' data. Source of data: ISDH ERC.

Notes - 2005
Source of data: ISDH ERC. Data for 2005 is now final.

Notes - 2004
2004 data not yet available. Estimate provided based on trend analysis.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will be 81% in 2006.

Status: Not Met (78.2% Provisional)

Activities that impacted this performance were:

MCSHC worked with the Healthy Start projects in Lake and Marion counties to address county needs. MCSHC assisted with training and certification of Community Health Workers (CHW) with Indianapolis Healthy Start, and worked collaboratively with the Northwest Healthy Start to train CHWs at Ivy Tech in Lake County.

MCSHC provided free pregnancy test to 104 agencies in 64 counties as a method of outreach. Agencies were expected to assist women with a positive pregnancy test into early prenatal care.

MCSHC shared natality statistics, including entrance into prenatal care with all targeted counties and provided technical assistance on model programs to assist in outreach and facilitate early entrance into prenatal care.

MCSHC developed a data collection tool with OMPP and MCOs to collect prenatal care coordination outcome data. All MCOs agreed to collect the assessment forms from all prenatal care coordinators in their networks. The data will identify access issues as well as care coordination outcomes. The prenatal care coordination combined assessment forms were published in a Medicaid bulletin March 6, 2006. MCSHC provided three regional trainings on the use of the forms with all state certified prenatal care coordinators in May, 2006.

The Indiana Access survey data from Marion County and Technical assistance was presented to all of the targeted counties. MCSHC and Indiana Friendly Access provided technical assistance on alternative methods of data collection such as focus groups, neighborhood conversations, mini-surveys.

At least 1 agency in two of the targeted counties (Allen, Elkhart, Lake, LaPorte, or St. Joseph) initiated phase 1 of Indiana Friendly Access training. Marion County WIC began the first phase of training in 2006 and Elkhart County is implementing phase 1 of Indiana Access in 4 agencies with the start of the new grant year, October 1, 2007.

MCSHC completed the Mini-PRAMS survey in LaPorte County. All of the targeted counties have done mini-PRAMS surveys except Allen County.

MCSHC updated Prenatal Care Coordination Certification (PNCC) training. Recertification of original PNCCs certified was implemented to update knowledge of latest best practices in prenatal care.

IU School of Nursing Institute of Action Research for Community Health completed first year evaluations of the Maternity Outreach Mobilization Services (MOMS) faith-based project, the Baby First Advocates program and the Westside Family Investment project as possible models of outreach and facilitation into early care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. MCSHC will provide outreach, case finding, referral, advocacy, and education of at risk pregnant women.	X			
2. 2. MCSHC will develop a brief guide of the Model Programs for Prenatal Care including Centering Pregnancy and Parenting, Maternity Outreach Mobilization Services (MOMS) and Baby First Advocates outreach programs.				X
3. 3. MCSHC will disseminate information about model programs that impact early entrance into prenatal care, such as Centering Pregnancy, MOMS, and Baby First Advocates.				X
4. 4. Indiana Perinatal Network (IPN) will expand the IPN Prenatal Care Guide (standards) to include preconception/interconception care by June 30, 2007.				X
5. 5. MCSHC will disseminate Baby First educational materials statewide and provide technical assistance for expansion of the media campaign into one additional county of concern by September 30, 2007.				X
6. 6. MCSHC will update and disseminate the Emergency Room Care of the Prenatal Patient Guide/ consensus statement to ensure proper referral and follow-up.				X
7. 7. MCSHC will work with Office of Medicaid Policy and Planning (OMPP) and five (5) Medicaid Managed Care Organizations (MCOs) to develop and maintain policies that facilitate early entrance into prenatal care for MCH populations.				X
8. 8. MCSHC will continue community health worker (CHW) task force activities to define levels of CHW care, and develop policies.				X
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 78.5% in 2007.

Activities to impact this performance objective include:

Funding of prenatal care coordination projects throughout the state will continue to provide outreach, case finding, referral, advocacy, and education of at risk pregnant women.

MCSHC will develop a brief guide of the Model Programs for Prenatal Care including Centering Pregnancy and Parenting, Maternity Outreach Mobilization Services (MOMS) and Baby First Advocates outreach programs. MCSHC will present the guide in the targeted counties (Marion, Elkhart, Lake, LaPorte, Allen and St. Joseph) by August 30, 2007.

MCSHC in collaboration with the Indiana Perinatal Network (IPN) and Indiana ACOG will update and expand the IPN Prenatal Care Guide (standards) to include preconception/interconception care by September 30, 2007.

MCSHC will continue dissemination of the Baby First educational materials statewide and provide technical assistance for expansion of the media campaign into one additional county of concern by September 30, 2007.

By September 30, 2007, MCSHC will update and disseminate the Emergency Room Care of the Prenatal Patient Guide/consensus statement to ensure proper referral and follow-up.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 79% in 2008.

Activities to impact this performance objective include:

County data books, including entrance into prenatal care will be published on the ISDH website and shared with local communities in counties with significant access problems.

Counties with access to care problems will receive technical assistance from MCSHC to identify barriers and plans to improve access.

Implement the Early Start program in at least one of the counties with poor access to care due to systems barriers.

Funding of prenatal care coordination projects throughout the state and the ISDH Free Pregnancy Testing program will continue to provide outreach, case finding, referral, advocacy and education of high risk pregnant women to facilitate early entrance into prenatal care.

MCSHC will disseminate information about model programs that impact early entrance into prenatal care in all communities with access problems.

MCSHC will work with Office of Medicaid Policy & Planning (OMPP) and MCOs to pilot a presumptive eligibility program.

D. State Performance Measures

State Performance Measure 1: *The number of data sets, including the NBS, UNHS, Lead, IBDPR, Immunizations, CSHCS, Vital Statistics, and First Steps Data, that are completely integrated into the Indiana Child Health Data Set.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					1
Annual Indicator				1	2
Numerator				1	2
Denominator	1	1	1	1	1
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	1	1	1	1	1

Notes - 2006
Source of Data: ISDH Data Integration Steering Committee

Notes - 2005
Application would not allow us to change the denominator nor the objective. We expect to fully integrate one additional data set per year.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: Fulfill at least 4 of the data access measures. (See Below)

Status: Two data sets are integrated.

Activities that impacted this performance were:

MCSHC continued to expand and define the Operational Data Store (ODS) and is now successfully importing data related to the Lead Screening program as well as receiving the revised first Data Mart for Newborn Screening output.

MCSHC developed additional Data Marts for other programs including Early Hearing Detection and Intervention Program. ISDH continued to flesh out coding for the chronic disease, immunization, and the new vital statistics system parts of the ODS.

The Data Integration Steering Committee, a "living" committee whose membership changes as the modules being worked on in the forefront come closer to completion, was again revised. This allowed MCSHC to complete five data access measures.

The new SSDI grant for Data Integration was received for a five-year period, at the conclusion of which at least 12 of the 16 data access measures will be completed despite the added complexity and the reduction in overall data integration funding from various sources.

Measurement of this performance measure has been changed to agree with the national data access measures to more accurately reflect data intergration status.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. 1. The ODS team, coordinated by the DISC will develop and test input and output from various sources, including the new Vital Records EBC, scheduled to go live in Jan. 2007.				X
2. 2. The ODS team will develop and integrate UNHS, Lead,				X

Indiana Birth Defects and Problems Registry, Immunizations, CSHCS, and First Steps data.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Activities

FY 2007 Performance Objective: At least one additional data set will be completely integrated into the Indiana Child Health Data Set. This was the objective under the old definition. Using the revised data access measures as a guide to be consistent with National performance measures, at least two new data sets will be completely integrated into the Indiana Child Health Data Set, with at least two additional data sets well under way in final development and testing.

Activities to impact this performance objective include:

The Operations Data Store (ODS) development team, coordinated by the Data Integration Steering Committee (DISC), will continue to develop and test input and output from various sources, most importantly the new Vital Records Electronic Birth Certificate (EBC), which went live in January 2007. Implementation is being staged, with the birth module completed prior to the death module. The significant change in the data fields on the birth certificate will enable us to obtain verified data rather than estimates for the Health Status Indicator related to Medicaid versus non-Medicaid population.

Universal Newborn Hearing Screening, Lead, Indiana Birth Defects and Problems Registry, Immunizations, Children's Special Health Care Services, and First Steps Data will also continue to be developed for integration into the ODS when completed.

c. Plan for the Coming Year

c. Plan for the Coming Year

c. Planned Activities for 2008

FY 2008 Performance Objective: Using the revised data access measures as a guide to be consistent with National performance measures, at least two new data sets will be completely integrated into the Indiana Child Health Data Set, with at least two additional data sets well under way in final development and testing.

Activities to impact this performance objective include:

Finish the integration of the Newborn Screening, Indiana Birth Defects and Problems Registry.

Begin integration work and testing of First Steps data.

Begin using verified data from the new Electronic Birth Certificate (EBC) for Health Status Capacity Indicators (HSCIs) related to Medicaid versus non-Medicaid populations.

State Performance Measure 2: *The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0 - 493.9) among children less than five years old.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	76.8	75.1	73.3	38	29
Annual Indicator	74.8	38.7	29.6	28.9	28.2
Numerator	3213	1664	1276	1242	
Denominator	429293	430166	430557	430439	
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	28	27	26	25	24

Notes - 2006
Actual data for FY2006 not yet available. Estimate provided based on previous two years' actual data.

Source of data: ISDH Chronic Disease Program

Notes - 2005
Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates. Source of data: ISDH Chronic Disease Program. Estimate provided based on previous year baseline.

Notes - 2004
Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates. Source of data: ISDH Chronic Disease Program. Estimate provided based on previous year baseline.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Measure: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old decrease to 29.0.

Status: Achieved (28.2%)

Activities that impacted this performance were:

The State Asthma Program updated the Asthma Burden Report, using the Behavioral Risk Factor Surveillance System (BRFSS) Child Asthma module and Child Health Call-Back module.

The Environmental Quality Workgroup reviewed Indiana voluntary and regulatory codes and made recommendations for change. The workgroup has reviewed and made recommendations for updates to the Indiana Schoolhouse Rule.

The Health Care Provider Workgroup developed an asthma best practices course for health care providers in Indiana. The State Asthma Program and the Health Care Provider workgroup contracted with the Indiana University (IU) School of Medicine, Division of Continuing Education to create and implement an asthma training course. Indiana University conducted a survey of

family physicians to identify the needs of Indiana primary care physicians as related to asthma guidelines training. ISDH, the InJAC Health Care Provider workgroup and IU worked collaboratively to design the course based on the results of the survey and discussions at several meetings of the InJAC Health Care Providers workgroup.

Taking Control of Asthma in Indiana (Asthma Management Guidelines Update) was offered in Bloomington, Richmond, Evansville, and Indianapolis October through December. Also, during the Indianapolis training, the course was offered via teleconferencing in six other locations throughout the state. Continuing education credits/units were offered to physicians, nurses, respiratory therapists, and pharmacists. There were 104 participants total.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. State Asthma Program will continue to update data Fact Sheets on Youth Risk Behavior Surveillance (YRBS) data as well as Behavior Risk Factor Surveillance System (BRFSS) data.				X
2. 2. State Asthma Program will disseminate educational materials to schools and early care settings.			X	
3. 3. Indiana Joint Asthma Coalition (InJAC) Environmental Quality Workgroup will develop materials for educational outreach.			X	
4. 4. InJAC Heath Care Provider Workgroup will sponsor continuing education opportunities for health care professionals				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Measure: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will drop to 28.0.

Activities to impact this performance objective include:

The Asthma Burden Report will be updated by December 2007 and will include BRFSS, hospitalization, Emergency Department, and mortality data. The CDC recommended the Report be updated every three years instead of yearly.

The State Asthma Program, with the Indiana Joint Asthma Coalition (InJAC), developed a media campaign about the seriousness of asthma. The State Asthma Program and InJAC are partnering with the Ad Council and the federal Environmental Protection Agency to localize the National Asthma Campaign. The Campaign is scheduled to run in late summer 2007. Target counties for the campaign include Lake, Marion, Blackford, Delaware, Fulton, Grant, Huntington, Jay, Jefferson, Lawrence, Switzerland, Vigo, Wabash, and Wells (based on high number and rate of hospitalizations for asthma).

The State Asthma Program, with InJAC Children and Youth Workgroup, developed an in-service training for school personnel and child care providers on asthma management. The State

Asthma Program and InJAC Children and Youth workgroup are currently analyzing data collected from a survey of school personnel (measuring knowledge, attitudes, and beliefs of asthma in school) to plan and implement training for school personnel.

c. Plan for the Coming Year
c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will drop to 27.0.

Activities to impact this performance objective include:

Plan and promote asthma outreach activities and events in 25% of Indiana counties to assist in providing the latest information on key educational messages.

Indiana schools and regulated early care settings will have an increased awareness of the asthma burden among children and youth and will be able to identify health and environmental factors in their facilities that contribute to the asthma burden among children and youth.

Support the development of support networks and community partnerships to provide resources and assistance to reduce the asthma burden in Indiana schools and regulated early child care settings.

Develop core curriculum standards to be incorporated into Indiana training programs for future primary care physicians, nurses, pharmacists, respiratory therapists, and other related professional training program.

Review of voluntary and regulatory codes is to be completed by 2009.

State Performance Measure 3: *The percent of live births to mothers who smoke.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	20.1	19.8	19.5	17.8	17.1
Annual Indicator	19.1	18.5	17.9	17.7	17.2
Numerator	16210	15954	15707	15589	
Denominator	84744	86382	87961	87864	
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	16.5	16	15.5	15	15

Notes - 2006
Source of data ISDH Epidemiology Resouce Center. Data for CY2006 not yet available. Estimate based on trend analysis.

Notes - 2005
Source of data ISDH Epidemiology Resouce Center. Denominator = occurrant births CY2005.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percent of live births to mothers who smoke will decrease to 17.10% in CY 2006.

Status: Achieved (17.2%)

Activities that impacted this performance were:

The ISDH Prenatal Substance Use Prevention Program (PSUPP) identified and provided educational and support services to 4,004 high risk, chemically dependent pregnant women.

PSUPP/MCSHC collaborated with Smoke Free Indiana to reach a broader audience and have greater impact on smoking cessation with pregnant women. The Indiana Tobacco Prevention Cessation (ITPC) program formed smoking cessation coalitions in all 92 counties.

PSUPP educated women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.

MCSHC informed all funded projects to refer pregnant women to the Quit Now program available by telephone at 1-800-QUIT-NOW and distributed new copies of the "You and Me Smoke-Free program and the "ASK" Protocol to all funded prenatal projects.

MCSHC provided materials promoting the Indiana Quit Line to all funded prenatal projects.

MCSHC came together with state collaborative partners to form the Coalition to Promote Smokefree Pregnancies (CPSP) to identify priority issues and develop interventions. (The Coalition to Promote Smokefree Pregnancies (CPSP) consisted of March of Dimes, Indiana Perinatal Network, Clarian Health Systems, American Lung Association (ALA), Indiana ACOG, MCSHC consultants, Smoke Free Indiana, Indiana Tobacco Prevention and Cessation, Marion County Minority Health, PSUPP director.

PSUPP participated in community events, health fairs, conferences, and other public forums.

PSUPP distributed educational items to providers indicating the importance of identifying at-risk clients.

PSUPP distributed information about the impact of substance use among pregnant women to the public.

PSUPP clinics (3) provided support groups for women in substance use cessation.

MCSHC provided a link to the web based training for providers for prenatal smoking cessation "Smoking Cessation for Pregnancy and Beyond--Learn Proven Strategies to Help Your Patients Quit".

PSUPP received funding from the Division of Mental Health with Federal funds from the Center for Substance Use Prevention and Maternal, Children's Special Health Care Services and the Indiana Tobacco Prevention and Cessation Agency.

PSUPP worked with the Bowen Research Center to study the impact of alcohol, drug and tobacco use on pregnant women in Indiana. The report was presented to the legislature by Oct. 1, 2006. It also included recommendations for needed services in Indiana.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. PSUPP/MCSHC will collaborate with Smoke Free Indiana to promote smoking cessation among pregnant women.				X
2. 2. PSUPP will educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.			X	
3. 3. MCSHC will inform all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW and will provide materials promoting the Quit Line to all funded prenatal projects.				X
4. 4. MCSHC will provide training on (Federal Resource Enabling Data) FRED to all funded prenatal projects on correct data entry on smoking usage per trimester.				X
5. 5. MCSHC will analyze the rate of smoking in the third trimester on a quarterly basis to determine training needs.				X
6. 6. PSUPP will distribute educational items to providers, including physician's offices, indicating the importance of identifying at-risk clients.				X
7. 7. PSUPP will distribute informational items about the impact of substance use among pregnant women to the public.				X
8. 8. MCSHC will provide a link to the web based training for providers for smoking cessation for pregnant women.				X
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Objective: The percent of live births to mothers who smoke will decrease to 16.5% in CY 2007.

Activities to impact this performance objective include:

The ISDH Prenatal Substance Use Prevention Program (PSUPP) identifies and provides educational and support services to high risk, chemically dependent pregnant women.

PSUPP/MCSHC is collaborating with Smoke Free Indiana to impact on smoking cessation with pregnant women. The Indiana Tobacco Prevention Cessation (ITPC) program county smoking cessation coalitions in five pilot cessations counties will be trained by Smoke Free Indiana to return to their counties and share information on prenatal smoking with all persons in the county through press releases, media campaigns, health fairs, presentations and trainings.

MCSHC continues to provide brochures on "You and Me Smoke-Free" program and on the "ASK" Protocol.

PSUPP will educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.

MCSHC will inform all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW and will provide materials promoting the Quit Line to all funded prenatal projects.

MCSHC will provide training on Federal Resource Enabling Data (FRED) to all funded prenatal projects on correct data entry on smoking usage per trimester.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The percent of live births to mothers who smoke will decrease to 16.0% in CY 2008.

Activities to impact this performance objective include:

The ISDH Prenatal Substance Use Prevention Program (PSUPP) will identify and provide educational and support services for high risk, chemically dependent pregnant women.

MCSHC will continue to provide brochures on "You and Me Smoke-Free" program and on the "ASK" Protocol.

PSUPP will educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.

MCSHC will continue to expect all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW and will provide materials promoting the Quit Line to all funded prenatal projects.

MCSHC will provide training on Federal Resource Enabling Data (FRED) to all funded prenatal projects on correct data entry on smoking usage per trimester.

MCSHC will analyze the rate of smoking in the third trimester on a quarterly basis to determine training needs.

PSUPP will continue to participate in community events, health fairs, conferences, and other public forums.

PSUPP will distribute educational items to providers, including physician's offices, indicating the importance of identifying at-risk clients.

PSUPP will distribute information about the impact of substance use among pregnant women to the public.

PSUPP clinics (3) will provide support groups for women in substance use cessation.

MCSHC will evaluate the success of the PSUPP projects on success of prenatal smoking cessation, and referrals to the Quit Line by each project. Data from the new birth certificate on the number of women self reporting smoking in the third trimester of pregnancy will be evaluated. ISDH will compare data on Medicaid clients with statewide data.

MSCHC will contract with the American Lung Association to provide "Freedom from Smoking for You and Your Baby" Train-the-Trainer workshops training to health professionals in an additional 5 counties identified with significantly high prenatal smoking rates.

MCSHC will complete the on-site training of OB providers and office staff in Crawford, Clark, Scott, Jefferson and Perry Counties. They will replicate prenatal office training in five more counties with significant prenatal smoking rates if pilot project shows success.

MCSHC will continue to promote the Indiana Tobacco Quit Line through media, and performance expectations of funded prenatal projects.

State Performance Measure 4: *The percent of black women (15 through 44) with a live birth whose prenatal care visits were adequate.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	65	66	67	62	63
Annual Indicator	61.6	61.6	61.3	60	61.1
Numerator	5694	5722			
Denominator	9243	9288			
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	64	65	66	67	67

Notes - 2006
Indicator will be provided by Epidemiology Resource Center later this year. Data provided for FY2006 based on trend analysis.

Notes - 2005
Indicator provided by Epidemiology Resource Center.

Notes - 2004
Indicator provided by Epidemiology Resource Center.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 63% in FY 2006.

Status: Achieved (61.1%)

Activities that impacted this performance were:

The ISDH Office of Minority Health (OMH) worked with local counties to support the "Grandmother's teas" to promote breastfeeding, the "Father Support Groups" to promote breastfeeding, and the "Shower Your Baby with Love", baby showers to promote prenatal care and healthy pregnancy among African American mothers. The OMH did not support the local minority health coalitions efforts this year due to loss of staff. Some county coalitions provided these baby showers and grandmother's teas with donations from the community.

MCSHC and Indiana Perinatal Network (IPN) disseminated perinatal outcomes through provider, consumer, and other stakeholder presentations and meetings in the 6 targeted counties to ensure that the planning and delivery of perinatal health care services meet the needs of the at-risk population.

MCSHC provided technical assistance to Allen, Elkhart, Lake, LaPorte, Marion, and St. Joseph counties to mobilize community partnerships between policymakers, health care providers, families, the general public, and others to form county coalitions to identify and solve perinatal disparity issues. Data from completed focus groups and community conversations was shared with each county. As counties identify problems, new focus groups may be initiated.

LaPorte Co. formed a coalition consisting of the two hospitals, Valparaiso University, social services agencies, county school corporation, private practitioners, health clinics, WIC, and faith-based organizations. The coalition formed subgroups based on county data.

The St. Joseph Co. Healthy Babies Coalition consisting of both hospitals, WIC, mental health, local Division of Families and Children, Planned Parenthood, St. Mary's College, Indiana University at South Bend, local clinic providers, substance use counseling and social service agencies, and Purdue Extension, met monthly to address disparity issues and act as the Community Action Team for Fetal/Infant Mortality Review (FIMR).

Lake Co. MCH Network, consisting of Healthy Families, mental health, managed care organization representatives, staff from 3 local health departments, community health center staff, representation from 2 hospitals, the City of Gary, MCH clinics, health providers, Ivy Tech Community College, Healthy Start, Purdue Extension, Head Start, Township trustees, Healthy Housing, WIC, prenatal care coordination, and the local minority health coalition, addressed disparity issues of safe sleep and started a crib program to prevent SIDS and asphyxia for minority families. The MCH network also acts as the community action team for FIMR.

Marion Co. Healthy Babies Coalition met quarterly with subcommittees meeting monthly. The coalition worked on general perinatal issues but has not tackled specific disparity issues as yet. Indianapolis Healthy Start worked on the disparity issue with its Baby First Advocates and outreach workers.

Elkhart Co. formed a coalition consisting of United Way, Women's Care Center, the Elkhart Co. Health Department, MCH clinics, hospital, social services, and will become the first county to adopt the Indiana Friendly Access Program training on cultural competence with a commitment to at least a 1-year training initiative.

Allen Co. formed a group to study disparity issues. MCSHC provided technical assistance to Allen Co. as that coalition developed.

Each of the 6 targeted counties, Allen, Elkhart, Lake, LaPorte, Marion and St. Joseph, received pieces of a tool kit, developed by IPN and MCSHC on perinatal disparities, including perinatal outcome data, research on black perinatal disparity, conducting a local needs assessment, how to do educational campaigns and marketing, community development, model neighborhood programs to address African American disparity issues.

MCSHC collaborated with State Minority Health Coalition to address disparities in Allen, Elkhart, Lake, LaPorte, Marion, and St. Joseph counties through faith-based programs. MCSHC along with the State Minority Health Coalition focused on chronic disease

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. MCSHC and IPN will share perinatal outcomes through presentations meetings in the six targeted counties to ensure the				X

planning and delivery of perinatal health care services meet the needs of the at-risk population.				
2. 2. MCSHC will provide ongoing technical assistance to 6 targeted counties to strengthen community partnerships between stakeholders to form county coalitions to identify and solve perinatal disparity issues.				X
3. 3. MCSHC will develop policies and plans that support individual and community efforts to improve perinatal health and revise the State Perinatal Strategic Plan with emphasis on African-American disparities, and social determinants.				X
4. 4. MCSHC will provide training to perinatal disparity coalitions on social determinants, life course perspective, impact on perinatal care, to implement local action plans, and exploring new approaches.				X
5. 5. FIMRs with focus on perinatal disparities will continue in 4 counties with resulting recommendations to reduce disparities and improve local perinatal systems.				X
6. 6. MCSHC will fund and evaluate the Memorial Hospital Minority Outreach Project in St. Joseph Co. and replicate in at least one more of the 5 targeted counties.				X
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Measure: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 64% in FY 2007.

Activities to impact this performance objective include:

MCSHC completed a ten year birth cohort of county and state birth outcomes by race and ethnicity.

MCSHC will publish on ISDH website.

MCSHC will disseminate through presentations in the six targeted counties to ensure that the planning and delivery of perinatal health care services meet the needs of the at-risk population.

MCSHC will conduct perinatal disparity summits in the five targeted disparity counties of Allen, Elkhart, Lake, Marion, and St. Joseph counties.

MCSHC is sharing state and local statistics on perinatal health issues

MCSHC will help counties identify specific barriers to prenatal care for black women in their county.

MCSHC will help counties develop a plan to improve access to prenatal care for black women.

MCSHC will develop policies and plans that support individual and community efforts to improve perinatal health and revise the State Perinatal Strategic Plan with emphasis on African-American disparities, social determinants, and community building. This is an infrastructure building

process with a vision of starting a strategic plan by the end of the grant year.

c. Plan for the Coming Year
c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 65% in FY 2008.

Activities to impact this performance objective include:

MCSHC will provide ongoing technical assistance to Allen, Elkhart, Lake, LaPorte, Marion, and St. Joseph counties to strengthen community partnerships between policymakers, health care providers, families, the general public, and others to form county coalitions to identify and solve perinatal disparity issues.

ISDH will provide at least yearly training to county perinatal disparity coalitions on cultural competency, social determinants in perinatal disparities, life course perspective, impact on perinatal care, how to use tools to create and implement local action plans, and exploring promising approaches for effective action.

MCSHC will continue to be a part of the Hoosier Healthwise Quality Improvement Committee, and work with OMPP through the Quality Strategy Prenatal Workgroup to reduce disparity issues in prenatal care.

MCSHC will publish best practice models of care to improve access to prenatal care and reduce disparity outcomes on the ISDH website. Pilot projects will be encouraged in the disparity counties.

The Centering pregnancy model of care will be encouraged as a best practice model in all disparity counties

MCSHC will work to increase the number of certified nurse midwives providing care in high risk neighborhoods.

The National Office of Minority Health media campaign "Know What to Do for Life" will be initiated in at least one of the disparity counties.

IPN and MCSHC addressed perinatal disparities by sponsoring a booth at the Indiana Black Expo Black and Minority Health Fair.

IPN will provide ongoing evaluation of the community based Doula program. MCSHC will assess the feasibility of replication based on outcomes and cost.

State Performance Measure 5: *The percentage of children age 0 to 7 years with blood lead levels equal to or greater than 10 Micrograms per deciliter.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					2.4

Annual Indicator				2.5	2.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	2.4	2.3	2.3	2.2	2.1

Notes - 2006
FY2006 data unavailable; baseline figure continued. ISDH LEAD program should be able to provide FY2006 data later n the year.

Notes - 2005
New performance measure, baseline data will establish future objectives. Source of projection: Indiana LEAD Program.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: During SFY 2006 the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will decrease to 2.4%.

Status: Objective Not Met (2.5%)

Activities that impacted this performance were:

In SFY 2006, 47,761 children were tested. 520 had a confirmed elevated blood lead level equal to or greater than ten (10) micrograms per deciliter of blood, for a percentage of 1.09%.

Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) worked with Maternal & Children's Special Health Care (MCSHC) to contract out the development of a template for a county regulation "Model Code" to require the testing of rental housing built prior to 1950, and of housing where a child has been lead poisoned including the requirement to make the housing unit lead safe prior to renting.

The ICLPPP has developed a model code template which lays out a number of choices in various areas for local governmental codes regulating lead hazard identification of rental and other housing. This template includes information on how local governments can implement effective lead poisoning prevention code enforcement in their communities.

ICLPPP planned to work with MCSHC to contract out a study to determine the state's costs of a child lead poisoned and the savings to the state of preventing a child from being lead poisoned. This information would be used to determine cost-benefits of making homes lead safe. This study was not contracted for lack of funds and staff vacancies in ICLPPP. As the program matures, and other funds become available, ICLPPP may pursue this activity at a future date.

ICLPPP disseminated the Screening and Medical Management form to all physicians in the State that serve children, including WIC, local health departments, and MCSHC clinics in an effort to increase the screening of children. The program continues to distribute the chart in trainings and other appropriate meetings. The forms are also being distributed through Managed Care Organizations, Office of Medicaid, local health departments, Head Start, Healthy Families, and other partners working on lead poisoning prevention efforts. Approximately 2000 physicians received the charts along with a letter from the Health Commissioner. An additional 25,000 charts have been distributed to clinics, and other providers.

A formal, statewide awareness campaign was abbreviated as it was not funded by the Centers for Disease Control and Prevention (CDC) grant. However, materials for a campaign were

developed and will be utilized in many ongoing training and conference activities of ICLPPP. This activity will also appear in 2007, as a collaborative effort with Indiana Black Expo, Inc. (IBE). IBE, received $360,000 through a HUD grant, to implement a two-year, statewide lead awareness campaign which will utilize ICLPPP materials, expertise, and other support.

ICLPPP worked with the Office of Medicaid Policy and Planning (OMPP) to pay for case management and environmental assessments of lead poisoned children at 10 micrograms of deciliter or greater. After several plans for Medicaid reimbursement have fallen through, ICLPPP has contracted with a consultant organization to assist in setting up local health department (LHD) Medicaid billing for lead activities. The activity will be continued in the 2007 year report, as progress has been made with LHD surveys and as we move into identifying specific LHDs and establish procedures for billing.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. ICLPP will evaluate the effectiveness of the dissemination of the Screening and Medical Management form to all physicians in the State that serve children, including WIC, local health departments, and MCSHC clinics.				X
2. 2. ICLPP and MCSHC will develop a template for a county regulation to require testing of rental housing built prior to 1950, and housing where a child has been lead poisoned requiring to make the housing unit lead safe.				X
3. 3. ICLPP and MCSHC will study the State's costs of preventing a child from being lead poisoned and state savings to treat a child and use this information to determine cost-benefits to making homes lead safe.				X
4. 4. ICLPP will evaluate the effectiveness of the awareness campaign to increase children tested and the importance of making homes lead safe.				X
5. 5. ICLPP will work with the OMPP to pay for case management and environmental assessments of lead poisoned children at 10 micrograms of deciliter or greater.				X
6. 6. ICLPP will implement all aspects of the Lead Elimination Plan.				X
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Measure: During SFY 2007, the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will decrease to 2.3%.

Activities to impact this performance objective include:

It is projected that by the end of SFY 2007, 58,349 children will have been tested. Also projected, 619 children will have a confirmed elevated blood lead level equal to or greater than ten (10) micrograms per deciliter of blood, for a percentage of 1.06%.

Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) was unable to evaluate the effectiveness of the dissemination of the Screening and Medical Management form to all physicians in the State that serve children, including WIC, local health departments, and MCSHC clinics due to the lack of CDC funds and a staff Epidemiologist vacancy.

ICLPP continues to work with Maternal & Children's Special Health Care (MCSHC) to make the local ordinance template and the cost benefit analysis available to all counties and municipalities and educate counties on the benefits of adopting such ordinance.

ICLPPP worked with three county health departments to present their program models at the October 2006 Lead Safe and Healthy Homes Conference.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008

FY 2008 Performance Objective: During FY 2008 the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will decrease to 1.6.

Activities to impact this performance objective include:
.
ICLPPP will improve the case management activities for tested children following the protocols prescribed by Indiana Administrative Code title 410, article 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING. Dependent on the tested blood lead level, case management may include: educational awareness, medical provider notification, home visits, provision of other assessments, environmental inspection, and other follow up activities.

ICLPPP will increase the number of housing units becoming lead safe by increasing the resources needed to locate, remediate, and clear lead hazards.

ICLPPP will continue work with the OMPP on various projects aimed at increasing the testing rate among Medicaid children. The projects include a statewide Medicaid provider of filter paper testing, a "report card" on MCO testing performance, Medicaid billing by local health departments, and other activities.

ICLPPP will collaborate with Indiana Department of Environmental Management (IDEM), Department of Workforce Development (DWD) and other agencies to increase the number of professionals who work with lead. This includes lead inspector and assessors, as well as contractors who are trained to work with lead remediation.

ICLPPP will collaborate with IDEM to implement the standardized risk assessment process and new data base.

ICLPPP will work toward the enforcement of current laws and regulations dealing with lead hazard control.

ICLPPP will make available local ordinance templates, model legislation, and other information to improve legal options for lead hazard control enforcement.

State Performance Measure 6: *The proportion of births occurring within 18 months of a previous birth to the same birth mother.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					18
Annual Indicator				18.4	18.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	17	16	15	14	14

Notes - 2006
FY2006 data unavailable; baseline continued.

Notes - 2005
New Performance Measure. Baseline data will be used to establish future objectives.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced from 18.4% to 18% in 2006.

Status: Not Achieved (18.4%)

Activities that impacted this performance were:

MCSHC funded the Indiana Family Health Council (IFHC), the state Title X Agency, to develop a Child Spacing Education Program regarding the benefits of spacing out the births of children. The program encourages relevant health care and family planning practitioners to provide their clients with appropriate child spacing materials. The program targeted the population in six high-risk counties.

IFHC, Indiana Perinatal Network (IPN), and MCSHC created a network of providers in Indiana to guide the project and to coordinate future activities. Initial implementation began in Delaware, Lake, Marion, and Vigo counties.

In April 2006, IPN and the issues subcommittee of the State Perinatal Advisory Board developed and reviewed the first draft of a consensus statement on unintended pregnancy/birth spacing to educate providers. MCSHC consultant staff served on the committee.

Indiana Access analyzed matched birth certificate data to the 70% of women who answered they did not want to be pregnant then or ever on the Indiana Access survey of 520 delivering mothers in Marion Co. Initial data shows that women were mostly single, less than high school education, Black or Hispanic. Women who wanted the baby were less likely to have a low birthweight baby. Analysis looked at demographic characteristics and a planned pregnancy, a mistimed pregnancy, and an unwanted pregnancy.

MCSHC participated in Indiana Access coalition activities relating to unintended pregnancy.

Indiana Access conducted face-to-face interviews concerning perceptions of unintended pregnancy with persons in targeted neighborhoods in Marion Co. Baby First Advocates completed 184 neighborhood surveys. Responses to terminology revealed that unintended pregnancies were most typically described in a negative fashion with such terms as "irresponsible", "mistake", "unfortunate" and "unwanted". The specific term "unintended" was rarely used, with "unplanned" being more common. The term "family planning" was rarely used with terms like "use protection" or "protect yourself" being more common. Preventive factors commonly mentioned by respondents included an increased focus on school, future opportunities and life goals, increased parental involvement and support, and additional information regarding sexuality. MCSHC provided technical assistance to Elkhart, South Bend, Allen counties to replicate the surveys as reports on completed surveys are shared with other counties. The counties felt replication of the survey was too expensive and will use the Marion County report to guide their interventions.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. MCSHC will implement a media campaign to reduce unintended pregnancies.			X	
2. 2. MCSHC, IPN, March of Dimes, Title X and other members of the Unintended Pregnancy committee will work with IDOE to add sexuality and pregnancy prevention to the curriculum of junior high school students.				X
3. 3. MCSHC will replicate the unintended pregnancy survey in at least one of the focus counties.			X	
4. 4. MCSHC will circulate a call to action document produced by the unintended subcommittee throughout the state with county or regional coalitions to develop action plans.				X
5. 5. MCSHC will share a birth cohort data analysis, used to identify commonalities in the subpopulation of women who do not space births at least 18 months.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY 2007 Current Activities

FY 2007 Performance Measure: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 17% in 2007.

Activities to impact this performance objective include:

MCSHC staff, IPN, March of Dimes, Title X and other members of the Unintended Pregnancy committee will contact DOE to begin working with DOE to add sexuality and pregnancy prevention to the curriculum of junior high school students.

A call to action document produced by the Unintended Pregnancy advisory group will be shared throughout the state with county or regional coalitions to develop action plans during a 2 day state summit Wed-Thurs, September 12-13, 2007.

A birth cohort data analysis will be utilized to identify commonalities in the subpopulation of women who do not space births at least 18 months. This information will be shared with each county to assist with targeting populations most at risk for short interval pregnancies and poor pregnancy outcomes. This report will be completed by September 2007 and placed on the MCSHC website.

c. Plan for the Coming Year

c. Plan for the Coming Year

c. Planned Activities for FY 2008

FY 2008 Performance Objective: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 16% in 2008.

Activities to impact this performance objective include:

Identify stakeholders from the state unintended pregnancy summit, September, 07 that will work on a state task force to address issues brought up at the summit. Begin work on implementation of a program to provide interpregnancy care for women who had a high risk pregnancy and a poor pregnancy outcome in 1 county.

Develop media messages that address interpregnancy intervals.

Work with Indiana ACOG to encourage providers to provide preconception and interconception care with messages on unintended pregnancy.

Continue to work with the Department of Education to develop a curriculum on Life Planning that would include pregnancy delay.

Unintended pregnancy media campaign will be implemented in four counties.

State Performance Measure 7: *Number of community/neighborhood partnerships begun in 5 targeted counties to identify perinatal disparities.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					1
Annual Indicator				1	1
Numerator				1	1
Denominator	1	1	1	1	1
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	1	1	1	1	1

Notes - 2005

Application would not allow us to change the denominator nor the objective. We expect to begin one additional partnership per year.

a. Last Year's Accomplishments

a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The number of targeted communities with such community/neighborhood partnerships will increase from 0 to 1 in 2006.

Status: Two (2) county partnerships were developed.

Activities that impacted this performance were:

MCSHC helped develop community/neighborhood partnerships in Marion and St. Joseph County.

The community/neighborhood partnership established in Marion County, represents a coalition with Healthy Start, Indiana Perinatal Network (IPN), the Marion County Minority Health Coalition and the Marion County Healthy Babies Consortium. Minority volunteers from 2 targeted zip codes provide outreach, health education, advocacy, and opinions on improving disparity issues.

In St. Joseph County a community/neighborhood partnership has been developed in collaboration with Memorial Hospital, Memorial Hospital prenatal care coordination program, Minority Health Coalition, Minority Outreach Program, and 9 neighborhood churches in a high-risk targeted zip code that includes a large minority population, to provide neighborhood education, outreach, case finding, prenatal care coordination and mentoring by church volunteers.

MCSHC provided technical assistance in development of coalitions to all six identified counties.

LaPorte County has formed a coalition consisting of the two hospitals, Valparaiso University, social services agencies, county school corporation, private practitioners, health clinics, WIC and the faith based community. The coalition formed subgroups based on county data.

St. Joseph County Healthy Babies Coalition, consisting of both hospitals, WIC, mental health, local Division of Families and Children, Planned Parenthood, St. Mary's College, Indiana University at South Bend, local clinic providers, substance use counseling and social service agencies, and Purdue Extension, among others, met monthly to address disparity issues and act as the Community Action Team for Fetal/Infant Mortality Review (FIMR).

The Lake County MCH Network met monthly, and consisted of Healthy Families, mental health, managed care organization representatives, staff from 3 local health departments, community health center staff, 2 hospitals, City of Gary, MCH clinics, health providers, Ivy Tech, Healthy Start, Purdue Extension, Head Start, town-ship trustees, Healthy Housing, WIC, prenatal care coordination, and the local minority health coalition. They network to address disparity issues of safe sleep and started a crib program to prevent SIDS and asphyxia for minority families. The Lake County MCH network also acted as the community action team for FIMR.

Marion County Healthy Babies Consortium met quarterly with subcommittees meeting monthly. The coalition worked on general perinatal issues but has not tackled specific disparity issues as yet. Indianapolis Healthy Start worked on the disparity issue with its Baby First Advocates and outreach workers.

Elkhart County formed a coalition with the United Way, Women's Care Center, local health department, MCH clinics, hospital, and social services agencies. Elkhart County became the first county to adopt the Indiana Friendly Access Program training on cultural competence with a commitment of at least a 1-year training initiative.

MCSHC and the State Action Learning Lab (ALL) Team developed pieces of a tool kit on perinatal disparities, including but not limited to; perinatal outcome data, research on black perinatal disparity, how to conduct a local needs assessment, coalition building, working with neighborhoods, how to do educational campaigns and marketing, community development, and

model neighborhood programs to address African American disparity issues. Parts of this took kit have been provided to each of the six targeted counties, Allen, Elkhart, Lake, LaPorte, Marion and St. Joseph.

MCSHC presented perinatal vital record outcomes, and focus group and town meeting results to each county coalition, and provided technical assistance to the six-targeted counties (Allen, Elkhart, Lake, LaPorte, Marion, St. Joseph) to assess social/system determinants that create barriers to early entrance into prenatal care in each county with use of at least one of the following tools: Indiana "Mini-Prenatal Risk Assessment Monitoring Surveillance (PRAMS)" surveys, targeted focus groups, ongoing town meetings, FIMR, Perinatal Periods of Risk (PPOR) to substantiate and enhance knowledge of problems.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. MCSHC will develop a brief guide of Model Programs for Prenatal Care – including Centering Pregnancy and Parenting, MOMS and Baby First Advocates outreach programs for communities and organizations.				X
2. 2. MCSHC will disseminate the Baby First educational campaign community digital tool-kit statewide and provide technical assistance for expansion.			X	
3. 3. MCSHC will provide technical assistance to the six targeted counties, as well as, other focus counties to implement model programs in at least 2 new counties.				X
4. 4. MCSHC will work with community health worker task forces to complete at least one training model of different level community health worker programs and implement use of community health workers in at least one county.				X
5. 5. MCSHC will provide technical assistance to Allen, Elkhart, Lake, LaPorte, Marion and St. Joseph counties to mobilize community partnerships.				X
6. 6. MCSHC will provide technical assistance to at least two additional Counties on recommendations from the FIMR outcomes report to implement additional fetal infant mortality reviews.				X
7. 7. MCSHC will facilitate training to county perinatal disparity coalitions.				X
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. Current Activities for FY 2007

FY 2007 Performance Measure Objective: The number of targeted communities with such community/ neighborhood partnerships will increase from 1 to 2 in 2007.

Activities to impact this performance objective include:

MCSHC will continue disseminating the Baby First educational campaign community digital tool-

kit statewide and provide technical assistance for expansion into one additional community by September 30, 2007.

By August 30, 2007 a brief guide of Model Programs for Prenatal Care -- how to get started, funded, and set goals including Centering Pregnancy and Parenting, MOMS and Baby First Advocates outreach programs for communities and organizations interested in taking action improve early entry into and the content of prenatal care will be developed. These guides will be provided to target county coalitions, funded MCH sites and County Health Departments and posted on the MCSHC web site.

MCSHC will provide technical assistance to the six targeted disparity counties, as well as, other focus counties to implement model programs in at least 2 new counties by September 30, 2007.

MCSHC will continue work with the community health worker task forces to complete at least one training model of different level community health worker programs and implement use of community health workers in at least one county in one program other than prenatal care coordination by September 30, 2007.

c. Plan for the Coming Year

c. Plan for the Coming Year
c. Planned Activities for FY 2008
FY 2008 Performance Objective: The number of targeted communities with such community/neighborhood partnerships will increase from 2 to 3 in 2008.

Activities to impact this performance objective include:

MCSHC will continue to provide technical assistance and follow-up to the five targeted disparity counties to help county coalitions address disparity issues. The 5 disparity summits will be followed up with a series of workshops on coalition building, cultural competence, and best practice models.

A perinatal health disparity consensus statement with best practices for provider patient interactions will be completed and published on the IPN website by September 30, 2008.

The Community Health worker Task Force will result in wide use of community health workers in a number of settings in 1 county by September 30, 2008.

The Indiana State Plan on Perinatal Disparities will be published by September 30, 2008. County disparity plans will be included.

A statewide summit on the Life course perspective and perinatal disparities will be planned.

MCSHC will work with the Office of Medicaid Policy and Planning, Office Of Women's Health, Indiana Perinatal Network, Indiana Minority Health Coalition, Governor's Office Of Faith Based Initiatives, state legislators, local county coalitions, and others to develop a preconception and interconception health program.

State Performance Measure 8: *The percentage of high school students who are overweight or at risk.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					24.9
Annual Indicator				25.7	25.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	24.1	23.4	22.7	22	22

Notes - 2006
Source of data will be ISDH WIC Program. FY2006 data unavailable at present. Data expected to be available prior to end of calendar year. Baseline figure used as projection for FY2006.

Notes - 2005
New Performance Measure. Baseline data will be used to establish future objectives.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
a. FY 2006 Accomplishments
FY 2006 Performance Objective: The percentage of high school students who are overweight will decrease by 3% over the five years. According to the 2005 Indiana YRBS, 15% of students in grades 9th through 12th were overweight, which is a statistically significant increase from the 2003 YRBS results of 11.5%. Accordingly, 14.3% of Indiana students were at risk for becoming overweight

Status: In Process

Activities that impacted this performance were:

MCSHC funded Community Nutrition/Obesity Prevention's (CNOP) Obesity Prevention Resource Guide development. CNOP's obesity Data Assessment Committee met 4 times in 2006. The first resource guide was developed to provide obesity baseline data for Indiana schools and other organizations in developing related programs and activities.

MCSHC funded Body Talk program to the Ruth Lilly Education Center to increase high school student's awareness of nutrition and physical activity. This is a three-day program targeting at high school students. It focuses on nutrition, physical activity, and body image. In 2006, more than 3500 students participated in the program.

CNOP formed the state Fruits and Veggies -- More Matters Advisory Council. A plan was developed for Indiana to participate in the national launch of the new National Fruit and Vegetable Program. The Advisory Council members and other key partners participated in the CDC regional trainings regarding the launch guidance and the licensing agreement. CNOP's strategy to launch CDC More Matters (new Five a Day program) through public health system was selected to be presented at the national conference call as a good practice model on December 5, 2006.

CNOP received a Recognition Award from CDC for 5/a Day program for partnership and leadership.

CNOP, in partnership with INDY COOKS program developed a proposal for healthy food demo (focusing on fresh fruits and vegetables) in Indiana schools.

CNOP formed the State Body and Soul Coalition to implement Body ad Soul program in Indiana's

African American churches to increase consumption of fruits and vegetables. The committee met monthly. Related coalition policies and procedures were developed. Information sessions were provided to 28 churches. Program implementation plan (logic model) for 2007 was developed.

In partnership with Indiana's Department of Education and the ISDH Epidemiology Resource Center, CNOP completed the first state School Weight and Height Collection report for the school year of 2005-2006. During the first year measurement (2005-2006 school year), local American Cancer Society officers and the local health department staff offered assistance to local schools with measurements. Recommendations were made to the Health Commissioner and other top leaders.

The finding indicated that during the 2005-2006 school year, 27 Indiana school districts outside Marion County provided weight and height data on a total of 19,109 students including 51.4 percent males and 48.6 percent females.

Of 19,091 students measured, 2.3 percent were underweight, 60.8 percent were normal weight, 17 percent were at risk of overweight, and 19.9 percent were overweight.

In comparison with Indiana's YRBS, the findings illustrated that the overweight rate identified through actual school weight and height measurements (including at risk for overweight) was 7.6 percent higher than the self-reported YRBS survey rate.

CNOP provided new food pyramid brochures to the MCH clinics to promote awareness of healthy eating and physical activities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. MCSHC and CNOP will analyze school weight and height collection data and make recommendations to the State Health Commissioner and the State Superintendent of Schools regarding procedure changes.				X
2. 2. CNOP will extend the Body and Soul Training program to African American churches to include programs and activities for school-age African American children.			X	
3. 3. CNOP will develop review criteria and complete a minimum of one site visit to each obesity prevention project.				X
4. 4. CNOP will provide workshops and presentations to selected MCH clinics regarding the new food pyramid, Five a Day, breastfeeding, and other obesity prevention approaches.			X	
5. 5. CNOP will develop and provide a tool kit for MCH families with young children regarding healthy eating and physical activity.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

b. FY2007 Current Activities

FY 2007 Performance Objective: The percentage of high school students who are overweight will decrease by 3% over the five years.

Activities to impact this performance objective include:

CNOP is using funding from the AmeriCorps Improving Health throughout Indiana program, which was developed based on CNOP's Community Lay Health Worker program. The program is providing positions to 8 MCH local projects to promote community outreach to local women, families, and children through various settings including local MCH clinics, schools and churches.

CNOP is participating providing expertise and support to the state working group regarding the school wellness issues. CNOP is reaching out to more than 9600 families and children and will providing information at 15 health fairs and displays this year.

CNOP is scheduled to provide more than 56 workshops and presentations to an estimate of 800 providers, school nurses, local health department officers, church leaders, volunteers, summer camp kids, college students, and parents regarding good nutrition and increase physical activities.

CNOP is developing Healthy Vending and Snack Bar Guidelines, Food Handling and Demo Policies and Procedures, Nutrition and Emergency Preparedness food supplies and brochures.

CNOP is providing articles to the Children's Special Health Care Services newsletter regarding childhood obesity.

c. Plan for the Coming Year
c. Plan for the Coming Year
c. Plan for the Coming Year
c. Planned Activities for 2008
FY 2008 Performance Objective: The percentage of high school students who are overweight will decrease by 3% from the FY 2006 established baseline in FY 2007.

Activities to impact this performance objective include:

CNOP will develop a tool kit for local communities to develop their community-based needs assessment survey. CNOP will develop a resource guide to use existing data to develop obesity prevention programs. MSCHC will continue funding to extend the effort toward the state Obesity Prevention Strategic Plan, which will focus on Childhood Obesity Prevention.

MCSHC will continue funding to the Body Talk program at the Ruth Lilly Education Center to increase high school student's awareness of nutrition and physical activity. A minimum of 10 new schools at underserved communities will be reached.

CNOP will provide 4 training trainer sessions to the local MCH clinics regarding CDC's sublicensing policies and procedures regarding Fruits and Veggies-More Matters program. Educational tool kit will be provided to all local MCH clinics to encourage their outreach to school setting to promote the program. In addition, CNOP will deliver an e-mail campaign to all the MCH clinics (4 times) to provide educational information and materials.

CNOP will modify School Weight and Height Collection Guidelines and policies. CNOP will continue to provide trainings/information sessions to schools that will be participating in the School Weight and Height Collection program. In collaboration with the Department of Education and the INDY COOKS program, CNOP will complete program development, vendor agreement, and provide nutrition education along with food demos to the selected schools that have

participated in the School Weight and Height Collection program. CNOP will continue to seek funding to implement the BMI4kidz proposal to encourage active participation.

CNOP will continue to lead the state Body and Soul coalition, develop and implement program strategies to enhance and monitor environmental and policy changes at church settings. It is also CNOP's goal to introduce MCH message to the churches that are participating in the Body and Soul Program.

CNOP will follow federal and state regulations to implement AmeriCorps Improving Health throughout Indiana. Along with positions provided to 8 MCH clinics, CNOP will also add effort to promote MCH effort through additional positions statewide for breastfeeding coalition promotions.

CNOP will continue our collaboration with MCSHC and the IPN to develop a Gestational Weight Gain grid and educational tool kit for providers and women who are pregnant pr planning to get pregnant, using the New Leaf curriculum as a model.

CNOP will select one MCH clinic as a site to pilot a Healthy Worksite program by using CDC Healthy Worksite model in 2007.

CNOP will provide emergency food supplies along with other educational materials to MCH clinics.

E. Health Status Indicators

Indiana has continued to submit the Health Status Indicators annually. Hoosiers or anyone can access these statistics included in the grant from the ISDH website. Some of these same data are also found on the website in the statistics that the ISDH Epidemiology Research Center provides. Hoosiers may access whichever data is most user-friendly.

Several of the Health Status Indicators--like the population demographics and the injury and STD statistics--were used as issue benchmarks to determine which counties in Indiana were in highest need of attention both for benchmark issues and overall. From this analysis for all Indiana counties, 30 focus counties were identified along with the issues that needed addressing within those counties. This analysis was included in the criteria for local funding in the MCSHC FY 2007-08 Request for Proposals.

These indicators will continue to be used as a monitoring tool, particularly for issues that others in ISDH or other agencies are taking the lead, (e.g. injury prevention and STDs). When appropriate, the statistics can also be used for evaluation.

Health Status Indicators 1A, 1B, 2A, and 2B -- low weight births, low weight singleton births, very low weight births, and very low weight singleton births -- directly provide information on that segment of Indiana's population. This supports a focus specifically on efforts to improve factors that contribute to low and very low birth weight babies, e.g., early entrance into prenatal care, nutritional education guidance, etc. By having several years' data on these measures it serves as a monitoring tool for our programs, and allows us to evaluate the success of the programs involved. At present, despite very small numbers, the multi-year trend is overall trending down or stabilized.

Health Status Indicators 3A, 3B, and 3C -- the death rate per 100,000 from, respectively, unintentional injuries to children 14 and younger, unintentional injuries to children 14 and younger due to motor vehicle crashes, and unintentional injuries to children 15 - 24 due to motor vehicle crashes -- directly provide information related to child mortality, both in motor vehicle accidents, and due to overall unintentional injuries in the youngest segment of the population through age

14. This supports a focus on addressing causes of those fatal injuries and allows for targeted educational programs to encourage preventive behaviours, e.g., proper car seat use, proper seat belt use. It serves as a monitoring tool for the success of those programs, and allows us to evaluate those programs in terms of effect on the target populations. At present the data on motor vehicle fatalities due to unintentional injuries is too varied to do a trend analysis on, but the overall death rate from unintentional injuries to children age 14 and younger is trending down, with an unexplained drop in 2003; 2004 data continues the downward trend from 2002.

Health Status Indicators 4A, 4B, and 4C -- identical to 3A, 3B, and 3C except as applied to nonfatal injuries -- directly provide much of the same information, support much of the same programmatic approaches, and also serve as a monitoring and evaluation tool as to the success of these approaches. The difference from HSI's 3A, 3B, and 3C is that success of the programs and approaches can be more reliably measured as the numbers of nonfatal injuries are greater than the numbers of fatal injuries. However, there are not enough years of data to establish a specific trend for HSI's 4A, 4B, and 4C at present. A few more data points, which will be collected over the next few years, will allow more detailed analysis.

Health Status Indicators 5A and 5B -- the rate per 1,000 women with a reported case of chlamydia among, respectively, women aged 15 through 19 and women aged 20 through 44 -- provides information related to one of the major sexually transmitted diseases in Indiana's women, both the teen-age and the young adult segment. This problem is growing among both populations. The upward trend supports the Indiana State Department of Health assigning a greater priority and more resources to combat this problem.

Health Status Indicators 6A through 12 are the Demographic health status indicators and give overall breakdowns which can be used in multiple ways.

Health Status Indicators 6A and 6B give total population by race, ethnicity, and age. This shows what segments of our population are experiencing the most growth and thus must be given more weight in programmatic terms. For example, Indiana is one of several states with an increasing Hispanic population. This knowledge helps us develop more multi-cultural programs, cultural awareness training, etc.

Health Status Indicators 7A and 7B give us similar information, but specifically related to birth rates. This allows for us to specifically aim the multi-cultural programs and awareness toward pregnant women and newborn programs.

Health Status Indicators 8A and 8B give us similar information to 7A and 7B except that it is related to death data rather than birth data.

In all cases, HSI 6A through 8B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

Health Status Indicator 9 is the most diverse of the Health Status Indicators, encompassing racial and ethnic breakdowns among the following populations for children 0-19 years of age:

Percent in households headed by single parent
Percent in TANF (grant) families
Number enrolled in Medicaid
Number enrolled in SCHIP
Number living in foster home care
Number enrolled in food stamp program
Number enrolled in WIC

Rate per 100,000 of juvenile crime arrests
Percentage of high school dropouts, grades 9 through 12

Each one of these involves specific programs, some internal to ISDH and some external. We have some programs and some targets for the disparities revealed by these data. This allows for monitoring results and evaluating what effect our programs have on these varying areas. Health Status Indicator 10 is the total of children ages 0 through 19 based on geographic living area. These areas are Metropolitan, Urban, Rural, and Frontier. Just over 2/3 of Indiana's children ages 0 through 19 live in urban areas, the vast majority of whom live in metropolitan areas. Just under 1/3 of Indiana's children ages 0 through 19 live in rural areas. Each living area represents unique challenges and benefits. For example, transportation to an adequate care facility may be more difficult in a rural area due to distance, whereas specific health problems (e.g., lead poisoning) may be more prevalent in a metropolitan setting due to a higher concentration of old housing with lead-based paint.

Health Status Indicators 11 and 12 deal with the percentage of people living in poverty, 11 being for the entire state population percentage and 12 being the percentage of those 0 through 19 years of age in said condition. Again, as in Health Status Indicator 10, poverty reflects unique challenges, and the different conditions of poverty--50% of poverty level versus 100% of poverty level versus 200% of poverty level--call for different programmatic approaches. While the basic factor, money, is the core of what is involved, there is a significant difference in whether a mother or child can pay for a service at all, even on a sliding scale, or whether that service has to be provided with no direct charge to the person served. The intent is to lower the number of persons living in poverty, but more specifically to raise those in extreme poverty to at least some level higher. Indiana has succeeded in lowering the percentage in the worst poverty category, which has caused some growth in the higher poverty level groups. By continuing to address the issues of health needs for all women and children in the state, and adding an additional focus as to the income aspect, it is hoped that in the future all levels of poverty, from 200% of poverty level and lower, will decrease.

In conclusion, Indiana's continual annual submission of the above Health Status Indicators, which Hoosiers or anyone can access from the ISDH website and from the ISDH Epidemiology Research Center, provides a great deal of data about many statistics that figure in to MCH program decisions. This helps to continually inform Indiana's residents, as well as those researching Indiana's statistics, to find information, compare data, and provide feedback through whatever means they wish including accessing the main ISDH web page or the MCH web page, submitting an e-mail, or sending a letter, or simply calling the agency and asking to speak with someone in any particular program. Also, in summary, several of the Health Status Indicators were used to assist in determining Indiana's counties in highest need of attention for single issues and overall, yielding 30 focus counties identified along with the issues that needed addressing within those counties. This was included in the criteria for local funding in the MCSHC FY 2007 08 Request for Proposals, and these indicators will continue to be used to monitor and evaluate programs.

F. Other Program Activities

The Indiana Family Helpline (IFHL) is designed to assist in promoting Maternal and Child Health Services, WIC and other programs and services throughout the state. In August 1992, the CSHCS Helpline merged with the IFHL to improve services to all Indiana families. During FY 2004, the IFHL responded to 18,828 calls and made 1,781 advocacy calls, resulting in 58,765 referrals.***/2008/During FY2006, the IFHL responded to 23,045 calls and made 2,183 advocacy calls resulting in 64,089 referrals.//2008//***

The Office of Cultural Diversity and Enrichment was created in March 2001 to help address the public health needs of minorities in Indiana. It was recognized that there was a need to place a stronger emphasis on cultural competency for health care professionals throughout the state, as

well as all health care professional employees in the ISDH. On a yearly basis, the Office has conducted the Minority Health Disparity survey. The fifth annual assessment of cultural competence for ISDH contractors described in this plan was designed to continue efforts to improve the ability of contractors to meet the needs of Indiana minority populations in an effective, culturally competent manner. The assessment serves as the basis for requiring contractors to receive training on cultural competence until they demonstrate acceptable levels of performance. If current ISDH contractors demonstrate a continued inability to meet ISDH goals regarding effective, efficient, culturally competent programs, ISDH will seek alternate culturally competent contractors. In order to address the public health needs of Indiana minority groups, the Office of Cultural Diversity and Enrichment began offering a two-day Cultural Competence Workshop twice a month and a one-day Advanced Cultural Competency Workshop that is also held twice a month. To date, 1,300 health care professionals have attended these workshops. The two-day workshops emphasize cultural knowledge and cultural differences, strategies for working with racial/ethnic populations, the principles of interpreter services, and discussion of four different cultures. (African American, Hispanic/Latino, Asian, Native American). The Advanced Workshops focus on dissimilarities in areas such as values, communication patterns, religion, beliefs, and health care professionals limited knowledge of other cultural groups.

The Indiana Child Care Health Consultant Program was established in FY 2003 with the Family Social Services Administration - Bureau of Child Development providing dollars from the Child Care Development Fund, Quality Initiatives Fund, to the State Department of Health to fund the project. The goal of the program is to increase the level of health and safety in out-of-home child care settings across Indiana through technical assistance and training for child care providers. The project provides another portal to services to increase the level of health and wellness that child care providers, the children they serve and their families, need. Program staff includes a contracted Project Director, six regional child care health consultants, and a part-time support person. The regional child care health consultants are located in the field and coordinate with the numerous individuals and agencies currently involved with child care providers. There are four programmatic functions of the program. They include:
- Identification of licensed, registered, and license-exempt child care settings;
- Collection of data such as the child care settings' programs, health and safety practices, the immunization status and health insurance coverage status of the enrollees, back-to-sleep practices, accident occurrences, and the smoke-free status of the setting;
- Creation or identification and distribution of appropriate health and safety educational materials for use by child care providers and parents;
- Provision of consultation for child care providers around health and safety issues in out-of-home child care settings.
Another major component of the program is data collection and report generation. Documentation of the activities of the regional child care health consultants and the resulting changes in health and safety practices in out-of-home child care settings, and the change in health status of the children enrolled in the programs are two of the major foci. This program is currently being re-designed.***/2008/In FY2006-2007 the focus shifted from state wide to three focus areas, Gary Indiana, Lawrence County, and Dubois, Spencer, and Perry Counties in Indiana. The consultants focused intensively of system development in these specific areas. Three ICCHC's conducted research with willing child care providers in these specific regions using a Health and Safety Assessment survey adapted from one used in California. They provided consultation on how to improve and are currently following up to assess improvement. //2008//***

In July 2003, the ISDH/MCSHCS received a two-year grant from MCHB to fund the Indiana Early Childhood Comprehensive Systems (ECCS) Program. The program will create an integrated, coordinated, comprehensive system of services for children from birth to five. The coordinated system will support ease of access to needed services, increase the utilization of appropriate services and support the role of the family as their child's first teacher. This initiative will help to ensure that a holistic system of care supports young children and they arrive at school healthy and ready to learn. A Core Partner (steering committee) group was created which met to

establish the Vision, Mission and Values of the program that provided the focus for the planning process The ECCS program staff with ISDH technical staff assistance established a website to promote public participation and facilitate communication across all committees. The site can be found at http://www.in.gov/isdh/programs/mch/eccs/eccsindex.htm. The ECCS Project Director is working closely with other groups promoting healthy children and families that have been initiated by the Governor, Lt. Governor and federal grant opportunities to ensure the work is not being duplicated and that all the groups are communicating and moving forward together. The Implementation phase of the ECCS is scheduled to begin as the statewide strategic plan has been completed and submitted in May 2005 to the Maternal and Child Health Bureau./2007/The ECCS program has been renamed Sunny Start.//2007//

/2007/In 2005 MCSHC initiated a series of special projects designed to use carryover funds to provide infrastructure improvements Statewide, including obesity prevention and abatement pilot projects, lead poisoning identification, screening and abatement, fetal/infant mortality reviews, and expansions of services into priority counties. These projects were designed to be funded for up to but no more than three years and many were renewed through September 30, 2007. However, continuing reductions in Title V allocations and increased expenses, including an increase in the Indirect Cost rate from 7.5% to 11.5% caused a drawdown in carryover funds at a greater than expected rate. MCSHC is recommending terminating most of the Special Projects effective September 30, 2006.//2007

G. Technical Assistance

Title V 2005 Technical Assistance Request

Description of Technical Assistance Requested
Workshops are needed to address issues surrounding the fact that in Indiana the number of meth labs (Methamphetamine) found statewide has risen from 43 in 1998 to 1549 in 2004, with 15,994 meth labs found producing the drug nationally in 2004.
Reasons Why Assistance Needed
The greatest concentration of Meth Labs has been in the Midwest, and from 2003 to 2004, Indiana moved up the list of labs busted nationwide from sixth place to fourth place. As a result, children of families involved in Methamphetamine use and production in Indiana are disproportionately suffering from various forms of abuse and neglect.
What state, organization or Individual would you suggest providing the TA

Not known at this time

Description of Technical Assistance Requested

Domestic Violence is the leading cause of serious injury to women, more than rape, mugging and car crashes combined. Domestic Violence includes but is not limited to Physical, Sexual, Emotional, and Financial abuse.
Reasons Why Assistance Needed
The number one killer of pregnant women nationally is homicide. Technical assistance for MCH funded and Non-funded projects is desperately needed.

What state, organization or Individual would you suggest providing the TA

Indiana Coalition Against Domestic Violence

/2007/ Implementation of the Lung Associations Smoking and Pregnant Women cessation program training. Indiana ranks #1 among the 50 states as having the greatest number of women who smoke while pregnant. Training is available from the American Lung Association of Indiana which is a non-profit, dedicated to reducing the effects of Lung disease through education.

Prevention of child abuse. Indiana provides programs for professional, Medical staff, Famalies, and Adolescents. Statistically Indiana ranks top 5 for child abuse. Training is available from Prevent Child Abuse Indiana, a non profit organization whose mission is to serve as a caralyst for preventing child abuse.//2007//

/2008/ Suicide is the 2nd leading cause of injury death in Indiana. In fact the state's rate has been higher than the national average for nearly a decade. The problem of suicide has an incredibly devastating effect on Hoosier families and communities--lost children, lost loved ones, lost employees, and lost resources. These losses are preventable. In 2001, US Surgeon General David Satcher released a report entitled, "National Strategy for Suicide Prevention:Goals and Objectives for Action." This report described suicide as a serious public health problem throughout the United States and introduced a blueprint for addressing suicide prevention through Awareness, Intervention, and Methodology (AIM). The Surgeon General also recommended that each state adopt a suicide prevention plan that would incorporate the national recommendations.

In response to the national call to action and the magnitude of the problem in the state, the Indiana Suicide Prevention Coalition (ISPC) formed in 2001 to address this issue. Statewide workshops are needed to insure that the MCSHC funded and Nonfunded network becomes familiar with Suicides devasting effects on Hoosiers and the strategy for Suicide Prevention as outlined by the Surgeon General and the Indiana Suicide Prevention Coalition. //2008//

V. Budget Narrative

A. Expenditures

Annual Budget Expenditure Narrative
FY'05 Budget Expenditures

Indiana's FY 2003 cost-cutting measures included early retirement incentives, a personnel furlough program, and a statewide hire freeze. These programs were implemented for all state personnel positions, whether funded by state funds or other (Federal) funds. While these measures were not continued in FY 2004, the long-term impact still resulted in significant expenditure reductions for both state and Federal funds in FY 2005, as reflected on Form 3, Form 4, and Form 5.

As a result, ISDH MCSHC increased funding allocations to local projects. Additionally, MCSHC implemented a one-time program to fund infrastructure building and pilot projects at the local level. These projects were funded for one to three years.

In FY 2005, ISDH MCSHC began spending down the large carryover. By FY 2007, the remaining carryover will have been reduced from over 5 million to less than one million dollars.***/2008/For 2008, due to the movement of costs from Title V to the state CSHCN budget and the reduction of funding for grants, the MCH program was able to carry over $1.216 million dollars.//2008//***

Maintenance of State Effort
In FY'89, Indiana's MCH Block Grant award was $10,527,556 and the State expended $11,539,520 in support of MCH activities. In FY'04 the MCH Block Grant award was $12,746,245 and the State expended $19,245,364 in support. In FY 2007 the MCH award is expected to be $11,890,921 and the State has available $39,092,884. State support includes money provided by state and local funds that MCSHC is authorized to spend on behalf of children with special health care needs. In FY 2004, MCHSC began counting the 30% match required of local projects as part of the Maintenance of State Effort. Line item expenditures for FY'89, FY'05 and budgeted amounts for FY'07 and FY08 are listed below:

State Funds
Expenditures in 1989
Expenditures in 2005
Expenditures in 2006
Budget for 2007
Budget for 2008

MCH Supplement
$193,223 expended in 1989
$0 expended in 2005
$0 expended in 2006
$0 budgeted for 2007
$0 budgeted for 2008
($176,700 was appropriated in both FY 2005 and FY 2007, but these funds are administratively withheld as a cost-cutting measure to address state budget shortfalls.)***/2008/The state appropriation continues to be withheld.//2008//***

Newborn Screening
$33,669 expended in 1989
$1,819,011 expended in 2005
$1,406,198 expended in 2006
$1,224,126 budgeted for 2007

$1,360,958 budgeted for 2008
(This program is funded by a provider fee for each newborn screened. This fee was increased from $7.50 to $30.00 in 2004.)

Children with Special Health Care Needs
$11,312,628 expended in 1989
$10,508,873 expended in 2005
$13,812,256 expended in 2006
$31,675,974 budgeted for 2007
$28,591,740 budgeted for 2008
(ISDH has seen an increase in projected revenue for State Children's Special Health Services funds. These are partially funded by county revenue that increased as a result of an increase in assessed property values. The budgeted amount includes carryover funds and reflects the balance in the dedicated account. These funds are dedicated to the CSHCS program to pay for covered health care for CSHCN. Funds available for FY 2007 will not all be used.)***/2008/Revenue for 2008 has been projected as a decrease based on a state appropriation reduction from an anticipated $5.9 million to $1.7 million.//2008//***

TDAB Meconium Screening
$0 expended in 1989
$59,371 expended in 2005
$55,840 expended in 2006
$62,496 budgeted for 2007
$61,246 budgeted for 2008

RESPECT (State sexual abstinence education)
$0 expended in 1989
$520,866 expended in 2005
$509,809 expended in 2006
$596,280 budgeted for 2007
$554,540 budgeted for 2008

TPSUPP (Prenatal Substance Use Prevention - State Tobacco Settlement Funds)
$0 expended in 1989
$181,899 expended in 2005
$120,270 expended in 2006
$153,333 budgeted for 2007
$147,000 budgeted for 2008

Local MCH Appropriations
(Municipal and County appropriations used by local MCH grantees as matching funds)
$0 expended in 1989
$674,567 expended in 2005
$1,119,588 expended in 2006
$753,805 budgeted for 2007
$1,172,528 budgeted for 2008

Other Matching Funds
(Funds from sources other than local appropriations and income used by local MCH grantees as matching funds)
$0 expended in 1989
$3,050,850 expended in 2005
$1,667,081 expended in 2006
$2,620,339 budgeted for 2007
$2,874,550 budgeted for 2008

Program Income
(Income from Medicaid, patient fees, insurance and donations used by local MCH grantees as matching funds)
$0 expended in 1989
$2,990,665 expended in 2005
$3,050,389 expended in 2006
$2,006,531 budgeted for 2007
$2,473,958 budgeted for 2008

TOTAL
$11,539,520 expended in 1989
$19,806,102 expended in 2005
$32,132,370 expended in 2006
$39,092,884 budgeted for 2007 (Funds available for FY 2007 will not all be used.)
$44,902,793 budgeted for 2008

FY'05 Unobligated Funds
Despite growing expenses and decreasing federal Title V awards, the large unobligated balance carried over from FY 2004 remained large coming into FY 2005.

In FY 2004, ISDH allowed ongoing MCH projects to apply for a 10% increase in requested funds to take into account previous flat-line allocations. Further, ISDH has implemented a one-time, short-term grant program to build infrastructure throughout the state. Additionally, Title V funds are now called upon to support allowable programs previously supported by funds such as the Preventive Health and Health Services Block Grant that are no longer available. This significantly reduced carryover amounts for FY 2005 through FY 2007. The projected carryover into FY 2007 will be $951,353.***/2008/The carry-over is $1.216 million as a result of effective budgeting and controlling expenditures, most effectively.//2008//***

Indiana operates its program on a first in first out basis; therefore the unobligated carryover will be expended first.

B. Budget

Annual Budget and Budget Justification

FY'07 Summary Budget

Component A: Services for Pregnant Women, Mothers, and Infants up to age one.
Component B: Preventive and Primary Care Services for Child and Adolescents.
Component C: Family-Centered, Community-Based, Coordinated Care and the development of Community-Based Systems of Care for Children with Special Health Care Needs and their Families.
Administrative Costs: Indirect Costs

Dollars | Percentages

Component A $ 3,862,661 | 32.48%
Component B $ 3,609,643 | 30.36%
Component C $ 3,780,754 | 31.80%
Administrative Cost $ 637,763 | 5.36%
Grant Total $ 11,890,821 | 100.00%

I. Direct Medical Care Services
The $19,530,717 budgeted at this level include all community grants that provide direct services and projected medical claims for CSHCN and hemophilia premiums.***/2008/FY2006 $14,199,521***

was expended for Direct Care; $14,973,082 and $16,340,115 for 2007 and 2008 are budgeted, respectively.//2008//

II. Enabling Services
The $24,050,864 budgeted at this level include all community grants that provide enabling services and all other CSHCS state funds not projected for direct medical care services.***/2008/FY2006, $8,175,574 was expended for Enabling Services; $25,791,692 and $16,943,524 are budgeted for FY2007 and FY 2008 respectively.//2008//***

III. Population Based Services
The $3,935,733 budgeted at this level include all community grants that will provide population based services, Newborn Screening funds, and Indiana RESPECT funds.***/2008/FY2006, $4,017,739 was expended for Population Based Services; $4,664,006 and $4,237,716 are budgeted FY 2007 and FY2008 respectively.//2008//***

IV. Infrastructure Building Services
The $8,433,775 budgeted at this level include salaries of all staff and other operating expenses (minus insurance premiums and community grant funds), the statewide needs assessment, data systems, and the Indiana Perinatal Network.***/2008/FY2006, $5,739,536 was expended for Infrastructure Building Services.//2008//***

Total FY 2007 budget is $55,190,207.

3.3.1 Completion of Budget Forms
See forms 3, 4, and 5.

3.3.2 Other Requirements
Maintenance of State Effort -- See comparisons of FY 1989 and FY 2005 expenditures and FY 2007 budget in previous section.

FY'07 Unobligated Funds
The projected unobligated balance for FY 2007 is $951,553, which reflects a significant decrease from the unobligated balance for FY 2006. ISDH structured costs for this program have grown while federal allocations have been reduced. As a result, ISDH MCSHC has had to reduce local MCH grants from a high of 8.5 million to less than 6.5 million dollars.

Carryover grew from FY 2001 through FY 2005 as a result of tightened state spending during FY 2002 through FY 2004. ISDH MCSHC took a number of steps to use these savings to build infrastructure throughout the state. Ongoing MCH project allocations were increased by nearly a million dollars from FY 2003 to FY 2004 and an additional one-time, short-term grant program was developed that obligated an additional $1,034,858 in FY 2005 and was designed to grant out up to an additional million dollars each year during FY 2006 and 2007. These short-term, one-time grants were primarily targeted to conducting Fetal Infant Mortality Reviews, community-based needs assessment and other infrastructure building projects.

Additionally Title V funds are being called upon to provide additional support for projects previously funded by funds no longer available such as the Preventive Health and Health Services Block Grant. This included a $335,000 grant to the Indiana Poison Control Call Center. Alternative funding is being sought for these expenditures.

Due to reduced available funding, MCSHC has to go from approximately $8.5 million in local grants down to less than $6.5 million. In addition, the new Medicaid eligibility requirements may increase the non-paying clients prenatal and child health clients served by local MCH projects. As a result, MCSHC is reducing grants to most existing local MCH projects by 6% to 9% from FY 2006 funding levels. Additionally, MCHSC is reducing or terminating a number of Special Projects that were projected to be funded for FY 2007. Also, some new projects that have been approved

will not be funded until funds become available. This will enable MCSHC to maintain as broad array of services to as large a population as possible and achieve the broadest healthy maternal, birth and child health outcomes with a minimal disruption in services.

To improve budget flexibility to provide maximum services to the MCH population, ISDH MCSHC is requesting a waiver for FY 2007 to allow Title V expenditures for CSHCN to be less than 30% of total Title V expenditures.***/2008/MCH took steps to request the waiver but clarification by MCHB pointed out that States had additional flexibility in allocating expenditures. With this additional flexibility MCH met the 30%.//2008//***

MCSHC has traditionally met the 30% requirement for expenditures related to CSHCN by using Title V funds to pay for staff who administer the State-funded CSHCN program and by funding local initiatives serving CSHCN. Indiana has a unique State-funded program to pay for services for CSHCN. This program expends more than $10 million annually. The State CSHCN program has sufficient State funds to support the CHSCN initiatives currently funded by Title V while remaining self-supporting. By transferring a greater responsibility for these costs to the State CSHCN funds, MCSHC could make more funds available for programs to ensure healthy birth outcomes.

Indirect Cost Rate Agreement
The rates listed below and approved in the Rate Agreement between ISDH and DHHS are for use on grants, contracts, and other agreements with the Federal Government subject to the conditions in Section III. It should be noted that Indiana considers indirect costs to be the administrative costs of the programs.

SECTION I: INDIRECT COSTS RATES*
RATETYPES FIXED FINAL PROV.(PROVISIONAL)

PRED.(PREDETERMINED)EFFECTIVEPERIOD
TYPES FROM TO RATES(%) LOCATIONS APPLICABLE
FIXED 07/01/05 06/30/06 7.0 All All Programs
PROV 07/01/06 until amended 11.5 All All Programs

*Based:
Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations), sub-awards and flow-through funds.
11.5 is the maximum rate currently projected for FY'07.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.